Blue Ribbon Commission for Health Care Reform

DRAFT

Final Report to the Colorado General Assembly

December 2007

Table of Contents

Executive Summary 4

Chapter 1: Background – The Nature of the Problem 9

Chapter 2: Objectives, Scope and Funding of the Commission 13

Chapter 3: Overview of Commission Activities 14

- **Timeline of Key Commission Activities** 14
- **Guiding Principles** 16

Chapter 4: Public Participation 17

- **Community Meetings** 19
- **Task Forces** 20

Chapter 5: Baseline Analysis of Health Coverage and Costs in Colorado 23

- **The Uninsured in Colorado** 23
- **Health Spending in Colorado** 24

Chapter 6: Health Reform Proposals 27

- **Submitted Proposals** 27
- **Selected Proposals** 28
- **Fifth Proposal** 29
- **Elements and Analyses of Five Proposals** 29
- **Introduction** 41
- **PART 1: Reduce Health Care Costs, while Enhancing Quality of Care** 43
- **PART 2: Improve Access to Care, with Mechanisms to Provide Choices** 54
- **PART 3: Adopt Recommendations as a Comprehensive Plan; Implement in Stages** 69
- **PART 4: Dissolve the Commission on January 31, 2008** 75
- **Financing** 75

Recommendations to the Federal Government 76

Issues for Further Study 77

Minority Reports 78

Appendices 79

Appendix 1: Senate Bill 208 79

Appendix 2: Specifications of Evaluated Health Care Reform Proposals 79

Appendix 3: Final Report of The Lewin Group 79

Appendix 4: Public Input 79

Appendix 5: Task Force Reports 79

Appendix 6: Summary of Commission Recommendations 80

Appendix 7: Medicaid Reform Ideas for Further Study 88

Medicaid Reform Ideas Recommended for Further Study 88

Appendix 9: State Administrative Functions under Commission Recommendations 99

Appendix 10: Legal Issues 100

Appendix 11: List of Commissioners 101

Executive Summary

The Colorado General Assembly created the Blue Ribbon Commission for Health Care Reform in 2006, charging it with identifying strategies to expand health care coverage and reduce health care costs for Coloradans.

Legislators took this action because Colorado, like most other states, faces urgent and interconnected problems. The cost of health insurance is escalating rapidly. That contributes to growing numbers of Coloradans without insurance. All Coloradans pay for the uninsured, as premiums rise still more to cover the cost of care provided to those who cannot pay. The cycle feeds on itself, and in the absence of action will only worsen over time.

Highlights of the problem

The rising cost of care and coverage

- Colorado spends more than $30 billion annually on health care, in both public programs and private spending.
- Health insurance premiums have risen dramatically in recent years, outpacing overall inflation and growth in wages. A study by the Colorado Health Institute shows that health insurance premiums more than doubled between 1996 and 2003. Figures from the Kaiser Family Foundation show that premiums increased by six percent in the last year alone.
- The share of median family income going to health insurance more than doubled from 7.7 percent in 1987 to 19 percent in 2005.

Growing numbers of uninsured

- Approximately 792,000 Coloradans, or about 17 percent of our population, are uninsured in any given month.
- This number is anticipated to grow, as the number of employers nationwide offering health coverage to their employees declined from 69 percent in 2000 to 60 percent in 2007.
- In Colorado, employees in small- and mid-sized companies were nearly twice as likely to be uninsured as those who worked for large employers.

Who are the uninsured?

- Seventy percent of the uninsured are in the workforce (or are the dependent of a worker).
  - About 11 percent of uninsured workers and dependents are eligible for but choose not to take the coverage offered by their employer.
  - Approximately 21 percent are ineligible for their employers' coverage.
  - Approximately 37.5 percent of Colorado's uninsured work for firms that do not offer health coverage to their employees.
- The uninsured are found in all income groups.
  - About 32 percent of the uninsured live in households that earn $20,000 or less annually.

- Approximately 75 percent live in a household with an annual income of $50,000 or less.
- Approximately 13 percent are in households that earn $75,000 or more annually; 6.5 percent earn more than $100,000 annually.

- Young adults are more likely than any other age group to lack insurance: about 40 percent of the uninsured are between the ages of 19 and 34.
- Close to 20 percent of the uninsured are children.
- About 10 percent are eligible for public programs (Medicaid and the Child Health Plan Plus) but not enrolled.
- Approximately 21 percent of the uninsured are not citizens of the US (either legal non-citizens or undocumented).

What do these facts tell us about what needs to be done?

- Extend health coverage to more people in order to minimize the cost shift from uncompensated care that represents a "hidden tax" and contributes to escalating health insurance premiums.
- Bring more healthy people into the insurance pool in order to lower the risk and thus the costs for everyone.

Highlights of the Commission's Work

With these issues as the impetus for its work, the Commission began meeting in November 2006 to fulfill its charge to extend coverage and reduce health care costs in Colorado.

The Commission requested proposals for comprehensive health reform from interested parties statewide and received 31 responses – far more than most other states that have used this approach, indicating the level of engagement on this issue in Colorado.

The Commission selected four proposals for technical "modeling" analysis by an independent vendor, The Lewin Group. These proposals represented a range of approaches to health reform, and were designed to offer lawmakers information on a variety of options. The Commission subsequently developed a fifth proposal of its own and subjected it to the same type of evaluation as the other four proposals.

In addition, the Commission worked diligently to receive input from the public and from stakeholder groups, conducting 24 public meetings statewide and convening four Advisory Task Forces to provide focused input from business, providers, rural communities and vulnerable populations.

Philosophy Underlying the Commission's Recommendations

The Commission now submits a package of recommendations for comprehensive health reform to the General Assembly. This package draws upon Lewin's baseline analysis of current health care costs and coverage in Colorado, the modeling results of all five proposals, input received at community meetings and feedback from its Advisory Task Forces.

The recommendations reflect certain philosophical imperatives:

- Everyone – individuals, employers, providers, insurers and the government – has a role to play in addressing Colorado's health care needs. All have a share in the responsibility; all will share in the benefits.
- "One size fits all" doesn't work in health care. People have differing income levels and health care needs, and health status can change in an instant. We need a range of interventions that respond to such differing needs.
- Some people simply cannot afford private insurance coverage. Those people ought to have access to public coverage for basic health care needs.
- Individuals should have meaningful choices and options that give them control over their own care and coverage decisions.
- Government, employers and insurers should promote and encourage healthy lifestyles and preventive care. Individuals, however, have responsibility for their own health and wellness.
- Because most Coloradans have insurance, we should build on the strengths of the current system, keeping and broadening what works to minimize dislocation for those who already have good coverage, while making important changes to better meet the needs of those who currently lack affordable health coverage.
- In order to accomplish our goals, we must maximize the federal funding available to Colorado – for example, through public program expansions that will enable us to draw down the maximum federal match, and through applications for federal waivers that will enable us to try new approaches to better meet the needs of Colorado's vulnerable populations.

What follows is not merely a laundry list of recommendations. It is a comprehensive, integrated package that will only succeed in fulfilling its promise if viewed and adopted as a whole.

Equally important is the staging of these recommendations. While the package should be viewed as a whole, it should not be enacted "in one fell swoop." There are essential building blocks among these recommendations that must be put in place before others, if those latter elements are to be successful. Readers will find specific suggestions about implementation timing in Chapter 7.

Taken together, our package of recommendations offer a bold yet realistic approach to providing high quality, affordable health care to all Coloradans.

Summary of Recommendations

Reduce Health Care Costs, while Enhancing Quality of Care

1) Slow the rate of growth of employer and private health insurance premiums by covering at least 85 percent of the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing cost-shifting.

2) Reduce employee premiums for health insurance by requiring employers to provide pre-tax plans for purchase of health coverage and by providing sliding-scale subsidies for employees making up to $80,000 annually to purchase insurance.

3) Reduce administrative costs by streamlining insurance processes, combining administrative functions of public health insurance programs and reviewing regulatory requirements with an eye toward minimizing administrative burden.

4) Increase use of prevention and chronic care management by allowing health insurance premiums to be reduced for enrollees who engage in healthy behaviors; eliminating copayments for preventive care and reducing them for chronic care management services; encouraging employers to provide workplace wellness programs; encouraging individual responsibility for personal health and wellness; and increasing funding to public health agencies.

5) Conduct a comprehensive review of current Colorado long-term care information

6) Improve end-of-life care by developing strategies to foster clinically, ethically, and culturally appropriate end-of-life care, including palliative and hospice care; and by asking patients to complete advance directives.

7) Commission an independent study to explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training.

8) Provide a medical home for all Coloradans and reimburse providers for care coordination and case management.

9) Support the adoption of health information technology through measures to support the creation of a statewide health information network, focusing on interoperability, and an electronic health record for every Coloradan.

10) Support the provision of evidence-based medicine by adopting population-specific care guidelines and performance measures and developing a statewide aggregated data system.

11) Pay providers based on quality, such as use of care guidelines, performance on quality measures, coordination of patient care, and use of health information technology.

12) Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g. Web site); require the Division of Insurance to report annually to the legislature regarding financial information on licensed carriers and public coverage programs

13) Promote consumer choice and direction in the health care system, giving consumers purchasing in the individual market a choice of minimum benefit plans; creating a "Connector" to facilitate individual and employer insurance purchases; increasing price and quality transparency; providing consumers evidence-based information at the point of care.

14) Build on the efforts of Colorado communities which have been proven over the years to enhance quality and lower cost.

15) Create a multi-stakeholder "Improving Value in Health Care Authority" to implement recommendations in this report and assess and report on their effectiveness.

Improve Access to Care, with Mechanisms to Provide Choices

16) Require every legal resident of Colorado to have at least a Minimum Benefit Plan, with provisions to make the mandate enforceable and providing affordability exemptions.

17) Implement measures to encourage employees to participate in employer-sponsored coverage, including requiring Colorado employers to establish a premium-only Section 125 plan that allows an employee to purchase health insurance with pre-tax dollars, providing subsidies for uninsured low-income workers below 300% FPL to purchase their employer's plan, enforcing waiting periods for eligibility for the premium subsidy and public programs

18) Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector."

19) Maximize access to/enrollment in private coverage for working lower-income Coloradans who are not offered coverage at the workplace by providing sliding-scale subsidies for those earning up to $80,000 annually.

20) Make changes to the individual insurance market, including guaranteed issue and modified community rating for those not eligible for an expanded CoverColorado program. Restructure and expand CoverColorado.

21) Restructure and combine Medicaid and the Child Health Plan *Plus* to cover legal parents and childless adults up to 205 percent of the Federal Poverty Level (FPL), children up to 250 percent FPL. Increase provider reimbursement; require enrollment in managed care where available;

22) Improve benefits and case management for the disabled and elderly in Medicaid, implementing integrated care delivery systems and promoting consumer-directed care.

23) Improve delivery of services to vulnerable populations by creating a Medically Correctable fund to assist with one-time expenses, a Medically Needy catastrophic care fund and a Medicaid buy-in program to enable disabled individuals to receive Medicaid benefits while employed; increasing the number of people on home and community-based services programs; and providing mental health parity in the minimum benefit plan.

24) Ease barriers to enrollment in public programs through automatic enrollment strategies and continuous eligibility; change the eligibility rules for public programs that result in families enrolling in multiple programs to receive medical care.

25) Enhance access to needed medical care, especially in rural Colorado where provider shortages are common by continuing to pay all qualified safety net providers enhanced reimbursement

for serving Medicaid patients; exploring ways to minimize barriers to physician and dentist extenders practicing to the full extent of their licensure; promoting and building upon the statewide nurse advice line; expanding telemedicine benefits for Medicaid and CHP+; and continuing to explore ways to develop, recruit and retain more providers.

26) Create a Consumer Advocacy Program

27) Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.

28) Continue to explore the feasibility of allowing employers to offer 24-hour coverage

Implementation

29) Adopt these recommendations as a comprehensive, integrated package but do so in stages, increasing efficiency and assuring access before expanding coverage.

Chapter 1: Background – The Nature of the Problem

Colorado, in common with other states, faces twin problems: rising costs for both health care and health coverage, and an associated increase in the number of residents without health insurance.

In order to understand these trends, it is important to look at the key components of the health care system, understanding how they contribute to the problems we face as well as how they might contribute to solutions.

Employer-Sponsored Coverage

Ever since World War II wage controls drove employers to seek other ways of attracting workers, the workplace has been the primary source of health coverage in America. The tax code and other federal laws have since reinforced this system.

For many Coloradans, this system works – about 58 percent of Coloradans are insured through their employers.1 Yet, as costs increase, there are cracks through which many others are falling. A recent survey by the Kaiser Foundation found that the number of employers nationwide offering health coverage to their employees declined from 69 percent in 2000 to 60 percent in 2007.2

And, a Colorado Health Institute analysis of Colorado's uninsured found that employees in small- and mid-sized companies were nearly twice as likely to be uninsured as those who

[1] "Characteristics of the Uninsured in Colorado," The Lewin Group, June 2007.
[2] "Employer Health Benefits 2007 Survey," Kaiser Family Foundation and Health Research and Education Trust, Sept. 2007.

worked for large employers.3 This is especially troubling given the significant role small businesses play in Colorado's economy.

Finally, many part-time and low-wage workers do not qualify for insurance offered by their employers.

Despite these difficulties, though, there are good reasons to maintain employer-sponsored coverage. The vast majority – 70 percent – are either workers or dependents of workers.4 Many employers view providing health coverage as a crucial way to attract employees.

Public Coverage

Another important piece of the health care puzzle in Colorado is public programs, such as Medicaid and the Child Health Plan Plus (CHP+). These programs provide an important safety net, with benefits that are especially designed to meet the needs of low-income and disabled people. However, Colorado's eligibility ceilings are low – Medicaid in Colorado covers only the poorest of the poor, leaving large numbers of low-income workers ineligible. And, eligibility rules (for Medicaid especially) are complicated; individuals' eligibility status can change monthly.

These issues are exacerbated by low reimbursements that have discouraged physicians from participating in Medicaid and CHP+. Limited provider participation in these programs has meant that even those who have coverage through public programs may not have true access to care.

Individual Coverage

The individual insurance market is an option for those who do not have access to employer-sponsored insurance and do not qualify for public coverage. However, because individual policies are subject to underwriting, people with health conditions can find themselves faced with prohibitively expensive premiums or even excluded from coverage altogether.

Colorado's high-risk plan, CoverColorado, is available to anyone who has been turned down for private insurance. However, its premiums are prohibitively expensive.

Action at the State v. Federal Level

Federal laws shape much of the health care landscape. The tax code allows workers to deduct the cost of health coverage purchased through their employer, but not insurance purchased on the individual market or as a self-employed individual. ERISA limits states' ability to regulate the actions of large and self-employed businesses, Public programs such as Medicaid that send federal dollars to the states impose restrictions on how those dollars can be used.

While these and other limits make health reform at the state level challenging, inaction at the federal level makes it imperative. Comprehensive health reform has been stymied in Congress on many occasions. Despite the prominence of health care in the platforms of all candidates for

[3] "Profile of the Uninsured in Colorado, 2004," Colorado Health Institute, January 2006.
[4] Characteristics of the Uninsured in Colorado," op. cit.

the 2008 presidential election, it is difficult to imagine that sweeping changes will be made soon in Washington.

The Need for Action

The cost of health coverage has risen dramatically in recent years, outpacing growth in wages. Both employers and employees are paying more for health insurance, with employees seeing greater percentage increases. While different studies use varying methodologies and timeframes and thus show different results, all those results illustrate the same trend:

- A study by the Colorado Health Institute found that the cost of family insurance coverage in Colorado more than doubled between 1996 and 2003, outpacing the 87 percent increase seen nationally.[5]
- Families USA calculates that family health premiums rose 82 percent in Colorado between 2000 and 2006, while wages increased by just 15 percent – a more than fivefold difference.[6]
- The federal Agency for Healthcare Research and Quality recently calculated that employers' share of health premiums for individual coverage, and nearly 58 percent for family coverage, between 2000 and 2005. Employees paid 61 percent more for their share of the average individual insurance premium and 60 percent more for family coverage in 2005 compared to 2000.[7]
- Costs continue to escalate. A recent study by the Kaiser Family Foundation and the Health Research and Educational Trust found that, nationwide, premiums for employer-sponsored health insurance rose an average of 6.1 percent in 2007 over the previous year. While that rate represents a leveling off from the study's findings in previous years, it nevertheless exceeds the increase in wages (3.7 percent) and the overall inflation rate (2.6 percent) during the period.[8]
- Rising premiums mean that families are spending an ever-growing share of their income on health insurance. Len Nichols of the New America Foundation calculates that the share of median family income going to health insurance more than doubled from 7.7 percent in 1987 to 19 percent in 2005.[9] This does not include additional costs such as copayments, deductibles, prescriptions, etc.

---

[5] "Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace," The Colorado Health Institute, Feb. 2007.

[6] "Premiums versus Paychecks," Families USA, December 2006.

7 "News and Numbers from AHRQ," posted on MedScape, Oct. 2, 2007; calculations based on Medical Expenditure Panel Survey.

8 "Employer Health Benefits 2007 Survey," Kaiser Family Foundation and Health Research and Education Trust, Sept. 2007; calculations drawn from telephone surveys of nearly 2,000 employers nationwide.

9 "Health Reform: Why Now, Why Here and Some Big Choices," Len M. Nichols Ph.D., presentation to the Blue Ribbon Commission for Health Care Reform, July 19, 2007; calculation based on data from Kaiser Family Foundation, Agency for Healthcare Research and Quality, and Current Population Survey.

As these rising costs contribute to greater numbers of uninsured, all Coloradans ultimately pay the price.

- We pay with our public health. When people lack health coverage, they tend to go without basic care such as annual checkups, immunizations, etc. Little problems can escalate to big problems; infectious diseases can spread, especially among children and the elderly; everyone can be compromised.
- We pay through our own health insurance premiums. A study commissioned by Families USA found that $934 of the average $12,000 annual family health insurance premium in Colorado in 2005 was the cost of caring for the uninsured.[10] When people without insurance do not pay for some or all of the care they receive, providers must try to recoup their own costs by charging insurance companies more – who, in turn, pass those increases along to their members. This phenomenon is known as the "cost shift," and is a hidden tax that contributes to rising insurance costs for everyone.

10 "The Added Cost of Care for the Uninsured in Colorado," Families USA, June 2005.

Chapter 2: Objectives, Scope and Funding of the Commission

The Colorado General Assembly created the Blue Ribbon Commission for Health Care Reform (also known as the 208 Commission; referred to in this document as "the Commission") in 2006. As directed by its enabling legislation, SB 06-208, the Commission's purpose is:

> …studying and establishing health care reform models to expand health care coverage and to decrease health care costs for Colorado residents. The Commission shall be authorized to examine options for expanding affordable health coverage for all Colorado residents in both the public and private sector markets, with special attention given to the uninsured, underinsured, and those at risk of financial hardship due to medical expenses.

The Commission's charge included:

- Soliciting comprehensive reform proposals from interested parties;
- Selecting between three and five proposals for in-depth technical assessment by an independent contractor;
- Holding statewide informational meetings at least once in each congressional district for the purpose of receiving public comments
- Presenting a final report to the General Assembly including an unbiased economic analysis, feasibility, and technical assessment of the favorable and unfavorable considerations of the various reform options, and specific recommendations.

SB 06-208 called for the Commission to present its report to the General Assembly by November 30, 2007. Subsequent legislation, HB 07-1360, extended that deadline until January 31, 2008.

SB 06-208 configured the Commission with 24 members, providing representation to consumers, health insurance purchasers, providers, business leaders and health care experts. Members were appointed by majority and minority leadership in the Colorado House of Representatives and Colorado Senate, and by then-Governor Owens. HB 07-1360 allowed Governor Ritter to make three additional appointees, bringing the total number of commissioners to 27. (For a complete list of commissioners, see Appendix 7.)

The General Assembly appropriated $100,000 to fund the Commission's activities, with one-half of that sum being "matching" funds that would only be released when an equivalent amount of private money was raised. The Commission's eventual budget was $1.16 million, with $1.06 million coming from the private sector. Of those private funds, 83 percent ($970,000) came as grants from nonprofit foundations and eight percent ($90,000) came from corporations. The state's allotment represented nine percent of the total budget.

Chapter 3: Overview of Commission Activities

Timeline of Key Commission Activities

November, 2006

First meeting of Commission

External Speakers/Presenters

Rep. Andrew Romanoff; Speaker, Colorado House of Representatives
Rep. Anne McGihon; House sponsor, SB 208
Rep. Tom Massey
Sen. Brandon Shaffer

December, 2006

Commission elects officers

Chair: William N. Lindsay III - President, Employee Benefits, Lockton Companies
Vice-Chair: Mark Wallace, MD - Executive Director, Weld County Dept. of Public Health & Environment; President, North Colorado Health Alliance

Commission establishes committees

Communications and Outreach
Evaluation Firm Selection
Health Reform Proposals
Operations

External Speakers/Presenters

Colorado Health Institute - overview of health coverage in Colorado

January, 2007

Commission develops guiding principles

External Speakers/Presenters

Martha King, National Conference of State Legislatures - lessons from other states
Lori Weigel, Public Opinion Strategies - survey data re: public attitudes toward health reform
Leo Tokar, Kaiser Permanente - health care cost drivers
Kathleen Stoll, Families USA - perspectives on health reform
Nina Owcharenko, Heritage Foundation - perspectives on health reform

March, 2007

Commission releases request for proposals for comprehensive health reform
Commission solicits bids for technical analysis of health reform proposals

William Jessee, Medical Group Management Assn. - reducing health care costs through administrative simplification
Enrique Martinez-Vidal, Academy Health - state coverage initiatives
Tamra Ward, Denver Metro Chamber of Commerce - statewide polling on health care

April, 2007	**Commission receives 31 responses to its request for health reform proposals**
	External Speakers/Presenters Clark Bouton, Colorado Progressive Coalition - initial findings from CPC health reform forums
May, 2007	**Commission selects evaluation vendor: The Lewin Group, Falls Church, VA** **Commission selects 4 proposals for evaluation** **Commission conducts 5 community meetings around the state** **Commission requests nominations for Advisory Task Forces (Business, Provider, Rural, Vulnerable Populations)**
June, 2007	**Commission selects Task Force participants** **The Lewin Group presents baseline analysis of health coverage and costs** **Evaluation of 4 proposals begins**
	External Speakers/Presenters Devon Herrick, National Center for Policy Analysis - consumer-driven health care
July, 2007	**Task Forces begin meeting** **Evaluation of 4 proposals continues** **Commission begins developing 5th proposal**
	External Speakers/Presenters Len Nichols, New America Foundation - Health reform: Why now, why here
August, 2007	**Evaluation of 4 proposals complete** **Task Forces report reactions to 4 proposals**
September, 2007	**Commission finalizes 5th proposal** **Evaluation of 5th proposal begins**
October, 2007	**Commission conducts 14 community meetings statewide** **Evaluation of 5th proposal continues** **Commission begins developing final recommendations** **Task Forces present final reports to Commission**
November, 2007	**Evaluation of 5th proposal complete** **Commission approves final recommendations**
December, 2007	**Lewin submits final report to Commission**

Guiding Principles

The foundation of the Commission's work is the "Guiding Principles" adopted by the Commission in January, 2007. Operational guideposts which themselves build upon the Commission's charge to reduce costs and expand access, these principles framed the Commission's request for health care reform proposals, development of its own proposal and the recommendations in this report.

- Protect and improve the health status of all Coloradans.
- Expand coverage of essential health care services for all Coloradans, with an emphasis on the uninsured and underinsured.
- Align incentives to provide high-quality, cost-effective and coordinated care.
- Support a system that is financially viable, sustainable and fair.
- Provide opportunities for meaningful choice and encourage personal responsibility.
- Emphasize wellness, prevention, health education, and consumer empowerment.

Chapter 4: Public Participation

The Commission took seriously its charge to solicit input from the public, creating numerous opportunities for Coloradans to comment and offer suggestions:

- As a statutorily created entity, all meetings of the Commission and its committees were open to the public, and included designated opportunities for public comment. Written comments submitted at those meetings were shared with commissioners, and meeting minutes included summaries of oral comments from the public.
- The Commission solicited e-mailed comments on its Web site, and shared those with commissioners.
- Between March and October, commissioners conducted 24 community meetings at locations throughout Colorado, traveling to each congressional district multiple times.
- The Commission created four Advisory Task Forces to provide focused feedback on all five proposals.

Commissioners reviewed and discussed input from the community meetings and the Task Forces at Commission and Final Report Committee meetings. The committee developing the Commission's fifth proposal also requested feedback from the Task Forces about specific ideas under consideration. The Final Report Committee explicitly considered the Task Force reports and the themes that emerged from community meetings in developing its recommendations.

All written comments received by the Commission, as well as notes and transcripts from the 24 community meetings, are available in a separate volume.

The following sections summarize input from the community meetings and the Advisory Task Forces.

Blue Ribbon Commission for Health Care Reform
Community Meetings Schedule

March 22-24

Locations: Alamosa, Aurora, Colorado Springs, Grand Junction, Greeley

Attendance: More than 200

Question posed:
- Input on criteria for health reform proposals: Comprehensiveness, Access, Coverage, Affordability, Portability, Benefits, Quality, Efficiency, Consumer Choice and Empowerment, Wellness and Prevention, and Sustainability.

May 10-12

Locations: Durango, Fort Collins, Glenwood Springs, Pueblo, Wheat Ridge

Attendance: Approximately 300

Questions posed:
- What are the one or two most important features that you feel must be included in any Colorado health care reform?
- What is the most important principle that should be considered in any reform effort?

October 4-13

Locations: Boulder, Canon City, Colorado Springs, Craig, Denver, Durango, Fort Collins, Golden, Grand Junction, Greeley, Lamar, Parker, Pueblo, Silverthorne

Attendance: More than 1,100

Questions posed:
- What should be the respective roles of individuals, employers, health care providers, health plans and government in assuring access to health care?
- Please discuss anything that you think the Commission should pay particular attention to in the five proposals being evaluated – OR anything that you think is missing from the conversation that would make a difference to you as the Commission moves forward with recommendations for health reform.

Community Meetings

As shown on the preceding page, each series of community meetings was framed around a specific set of questions. In addition to or instead of responses to those specific questions, many attendees shared personal stories about their experiences with the health care system and their own viewpoints about what the Commission should do.

Most attendees at the community meetings were consumers; a number of providers and some elected officials also attended. A handful of speakers at each meeting provided business or insurance viewpoints.

Certain key themes emerged from all meetings:

- There was a strong sentiment that we can do better. Many comments indicated that everyone – all individuals, all sectors – has a role to play in fixing the system.
- Concern about the cost of care recurred throughout the meetings.
- Many attendees expressed a strong desire for simplicity, regardless of the eventual system adopted.
- Some participants called for an explicit acknowledgment that hard choices must be made and discussed the need for some kind of limitation on benefits.
- At the same time, though, many participants expressed concerns about limited benefit packages and underinsurance.
- In many communities, a sizable percentage of attendees advocated for a single-payer system.
- Some attendees advocated for the preservation of individual choice and free-market approaches, such as increased access to HSAs and continued ability to select catastrophic/major medical coverage only.
- Numerous attendees, both consumers and providers, noted that coverage does not equal access. There were many comments about the need for ways to attract and retain providers to public programs, safety net providers and rural areas. Suggestions included increased use of advanced practice nurses and alternative providers.
- A number of participants stressed the need for increased funding for Medicaid services for the disabled, in order to reduce waiting lists and expand eligibility for home and community-based services.
- Those on public programs noted the difficulty of navigating the system, and called for simplifications.
- Many attendees called for integrating behavioral and physical health coverage, providing more funding for mental health and substance abuse, and incorporating dental with medical coverage.
- Concerns about long-term care – especially access to home care – featured prominently.
- Numerous participants urged commissioners to focus on health, wellness and preventive care, and noted the importance of incorporating public health efforts into reform approaches.

- Reaction to the individual mandate was mixed; those who supported it generally did so with a caution that it include ways to make insurance affordable.

Task Forces

The Commission received approximately 360 responses to its request for nominations to its four Advisory Task Forces. Commissioners appointed 15 members to the Business, Provider and Rural Task Forces, respectively, and 20 members to the Vulnerable Populations Task Force. Each Task Force was co-chaired by a commissioner and a Task Force member. (Lists of all Task Force participants and co-chairs may be found in Appendix 4.)

The following summarizes key recommendations from each of the Advisory Task Forces. The Task Force reports reflect additional considerations and richness of analysis; we encourage readers to refer to those complete reports in Appendix 4.

At the end of Chapter 7, "Recommendations to the Colorado General Assembly," readers will find an expanded version of the information below, indicating which of these Task Force recommendations were included in the final report.

Business Task Force Recommendations
Do not require employers to offer insurance or pay an assessment.
Exempt businesses with fewer than 10 employees from providing Section 125 plans.
Require Coloradans to have health insurance
Expand public programs to reduce cost-shifting, with considerations for the effect on state taxes and provider reimbursement
Structure premium subsidies to reduce administrative burden on employers

Provider Task Force Recommendations
Enable the provision, coordination and integration of patient-centered care, including "healthy hand-offs."
Encourage the development of a statewide system aggregating data from all payer plans, public and private.
Standardize benefit packages, claim forms, payment processes, etc across health plans to improve transparency and minimize administrative costs.
Integrate public and private physical health systems to incent consumer adherence and enable care to be provided by the most appropriate health care provider.
Get serious about changing reimbursements and incentives across all payers—public and private
Develop and expand state-based loan repayment/forgiveness systems/tax credits and other mechanisms to recruit and retain health care workers who will serve the underserved and provide a primary care based health care home for all.

Rural Task Force Recommendations
Use the Rural Urban Commuter Area definition of rural.
Test reform proposals to assure that safety net providers are not negatively affected.
Expand the scope of practice for non-physician health care professionals.
Increase funding to health care provider loan repayment providers who serve in Health Professional Shortage Areas.
Increase funding and marketing for medical education of providers who are on a rural track program in a primary care specialty.
Assure basic plan coverage to include oral health, behavioral health and vision care services.
Modify state regulations that prevent or set unacceptably high standards for the co-location and mixed use of some healthcare facilities.
Increase Medicaid reimbursement to parity with Medicare reimbursement in designated Health Professional Shortage Areas.
Assure adequate technical infrastructure and staff for telemedicine programs in rural areas to deliver chronic disease management and specialty consultation.
The use of a 24-hour telephone triage nurse line for patients will benefit rural populations.
Increase support for community-based organizations and local governments to assist families through eligibility and enrollment processes.
Enrollment in any state mandated health plan must occur automatically at the point of service, if the patient has not previously enrolled in an insurance plan.
The use of an insurance connector is likely to benefit rural populations; however, access to a connector should not be limited to the web.
Any governing body, which emerges from reform efforts, must include at least proportional representation from rural areas of Colorado.
Test any geographic community rating proposals, which isolate rural populations from urban populations, to assure that they do not disadvantage rural populations.
Test all proposed financing mechanisms to determine if they will disparately affect rural populations.
Test economic incentives to providers and insurance plans to assure that modeling considers the limited health care provider capacity in most rural areas of Colorado.
Establish rules to protect rural providers from unreasonable financial risk.
Healthcare reform must place a greater emphasis on wellness and prevention by increasing funding for the public health system.

Vulnerable Populations Task Force Recommendations
The safety net must be preserved and strengthened
Long-term care needs to be evaluated and planned for in detail, both current and projected future needs.
Any new proposal should include existing mandates provided by state law.
Build on successful local initiatives that are working for vulnerable populations.
Ensure that insurance plans provide comprehensive, high quality healthcare.
Focus on wellness and prevention. Incentivize consumers to engage in healthy behaviors and use appropriate preventive care. Eliminate co-payments for evidence based preventive care such as mammography screening.
Decrease complexity of health care plans and provide consumer education in acceptable mediums. Provide tools that enable consumers to make informed choices. Health care plans should be easy to navigate.
Provide consumer/family friendly appeals processes with advance notice and ombudsmen.
Consumer satisfaction data should be collected and reported by an entity without conflict of interest.
Provide transparency and accountability.
Contain administrative costs while providing high quality comprehensive care, i.e. National Association of Community Health Centers.
Expand Health Information Technology to allow quality seamless care, reduce medical error and forgo the need to duplicate care.
Recognize the value of culturally appropriate and holistic medicine including non-allopathic medicine and traditional healers/non-traditional western providers.
Provide continuous coverage with portability that allows interstate travel and reciprocity with other states.
Promote research into best medical practices for vulnerable populations.
Expand Medicaid to Federal Levels. Endorse Medicaid Buy-In and Ticket to Work.
Decrease the complexity of Medicaid via: a simplified application process, 12 months continuous eligibility, presumptive eligibility, passive reenrollment, and elimination of unnecessary verifications; expansion of the state definition of developmental disability to match the federal definition and consolidate the 14 Medicaid Waiver programs accordingly
Increase reimbursement for Medicaid providers, with incentives for those who provide quality care to high needs populations.
Build on the success of the Consumer-Directed Attendant Support Program by expediting implementation of HB 05-1243.
Enable consumer directed care for Medicaid DME purchase to maximize cost savings
Allow Medicaid services to be provided in the family home
Encourage Medicaid fraud detection via consumer education and incentives
Expand Medicaid benefits to include oral/dental, glasses, hearing aids, transportation and respite care
Allow Medicaid reciprocity with neighboring states
Realize cost savings by facilitating the transition of nursing home residents desiring community placement out of institutions
Develop a process to evaluate in 2 years whether changes have had an impact on the health of Colorado's vulnerable populations and the number of uninsured.

Chapter 5: Baseline Analysis of Health Coverage and Costs in Colorado

The Commission contracted with The Lewin Group of Falls Church, Va., to perform technical evaluation ("modeling") of selected health reform proposals.

Lewin first analyzed the current landscape of health coverage and costs in Colorado, seeking to develop the most timely and accurate pictures of the insured and uninsured and the nature of health spending in Colorado. Highlights of these findings are presented below. However, readers are strongly encouraged to review the complete reports, which are available in Attachment 4 (included as appendices to "Technical Assessment of Health Reform Proposals").

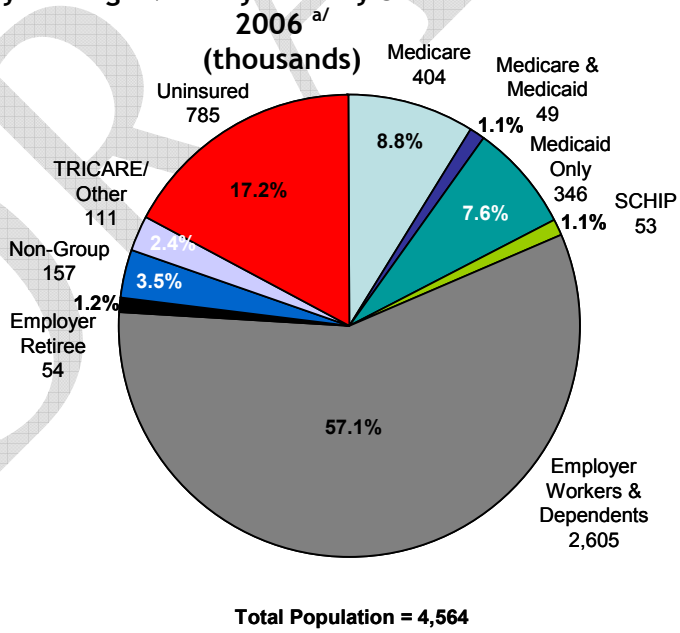
These analyses were essential to the Commission's work. In addition to providing a baseline from which to estimate coverage and cost impacts of each reform proposal, this information illustrated vividly the very specific problems the Commission should address in its recommendations, as discussed in Chapter 7.

The Uninsured in Colorado

Lewin estimates that approximately 785,000 Coloradans – or about 17 percent of the state's population – were estimated to lack health coverage in the period 2004-2006. By 2008, Lewin estimates that the number of uninsured will grow to nearly 792,000.[11]

Colorado Residents by Average Monthly Primary Source of Health Insurance: 2004-2006 [a/]

(thousands)



Total Population = 4,564

a/ Primary payer is determined on the basis of prevailing coordination of benefits practices now in use.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

[11] "Characteristics of the Uninsured in Colorado," The Lewin Group, June 2007.

Digging deeper, Lewin's analysis of Colorado's uninsured population reveals important details, including:

- Seventy percent of the uninsured are in the workforce (or are the dependent of a worker).
  - About 11 percent of uninsured workers and dependents are eligible for but choose not to take the coverage offered by their employer.
  - Approximately 21 percent are ineligible for their employers' coverage.
  - Approximately 37.5 percent of Colorado's uninsured work for firms that do not offer health coverage to their employees.
- The uninsured are found in all income groups.
  - About 32 percent of the uninsured live in households that earn $20,000 or less annually.
  - Approximately 75 percent live in a household with an annual income of $50,000 or less.
  - Approximately 13 percent are in households that earn $75,000 or more annually; 6.5 percent earn more than $100,000 annually.
- Young adults are more likely than any other age group to lack insurance: about 40 percent of the uninsured are between the ages of 19 and 34.
- Close to 20 percent of the uninsured are children.
- About 10 percent are eligible for public programs (Medicaid and the Child Health Plan Plus) but not enrolled.
- Approximately 21 percent of the uninsured are not citizens of the US (either legal non-citizens or undocumented).

(For additional detail, see Lewin's complete analysis, "Characteristics of the Uninsured in Colorado," in Attachment 4.)

These findings have significant implications for policymakers, and shaped the Commission's final recommendations.

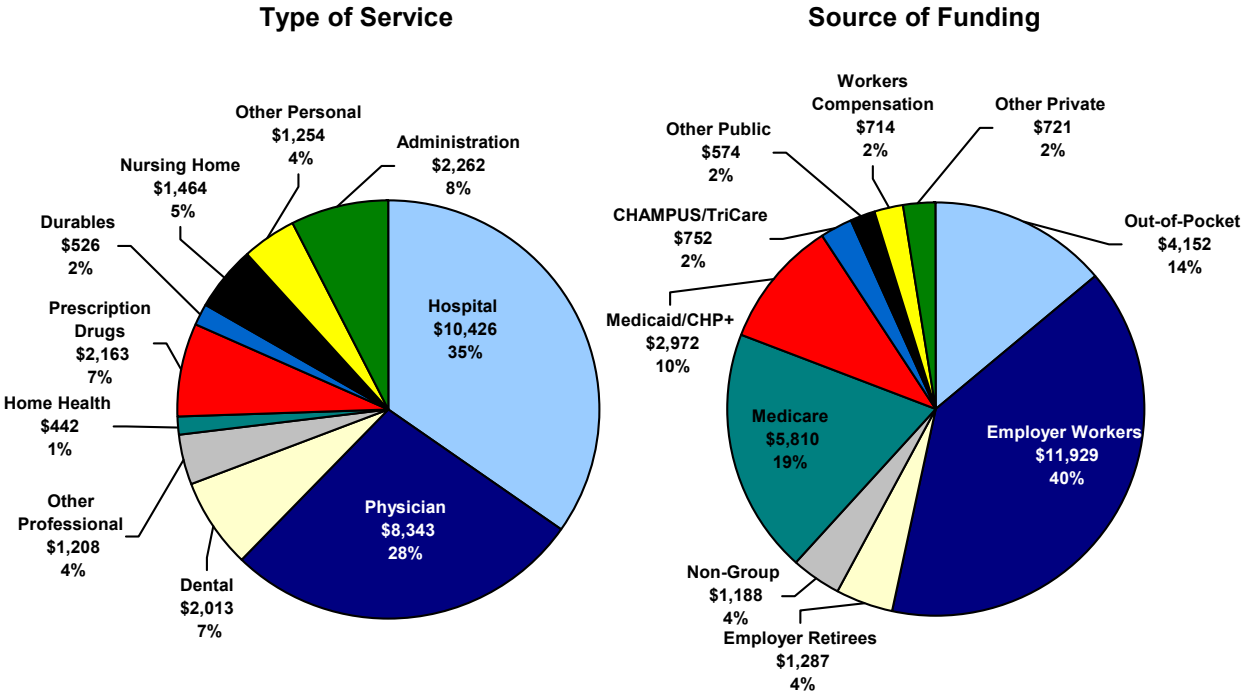
Health Spending in Colorado

Lewin estimates that, in 2007-2008, total spending on health care in Colorado will total approximately $30.1 billion.[12] This includes both public sector (e.g., Medicaid, Child Health Plan Plus, etc.) and private sector (e.g., health insurance premiums, copayments, etc.) spending.

The charts on the following page break down that total by type of service and source of funding.

[12] "Health Spending in Colorado," The Lewin Group, June 2007.

FY 2007-2008 Estimated Spending in Colorado by Type of Service and Source of Funding (millions)

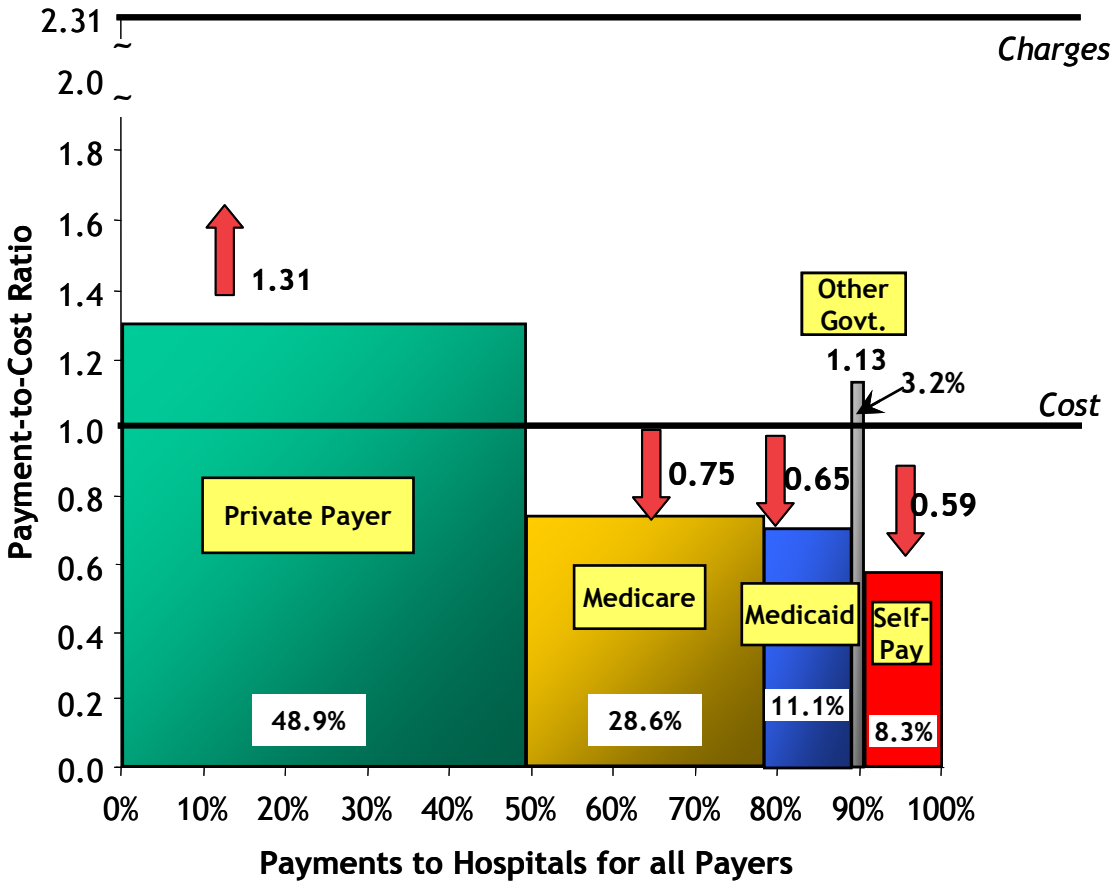


Note that percentages may not add to 100 percent because of rounding.

Lewin's analysis reveals that we all pay for the uninsured through the "cost shift." That is, when hospitals and other providers care for people without insurance who do not have the means to pay for their care, and when they care for enrollees in public programs (e.g., Medicaid, Child Health Plan Plus, etc.) at lower rates, providers must try to recoup the costs they have incurred by increasing the rates they negotiate with insurance companies. Insurers, in turn, pass those increases along to consumers in the form of higher premiums.

The figure on the following page illustrates this dynamic for Colorado hospitals.

Summary Comparison of Hospital Payment Levels in Colorado



Source: The Lewin Group analysis of Colorado Hospital Association data

The chart illustrates the difference between what hospital services cost and what is paid to them. Uninsured/self-paying populations pay 59 percent of the cost of the care provided to them; Medicaid covers 65 percent of the cost of care; Medicare covers 75 percent of the cost. Because they all pay less than cost, those with private insurance end up paying 131 percent of costs.[13]

Using data provided by the Colorado Hospital Association, Lewin estimates FY 2007-2008 uncompensated charity care (that is, excluding bad debt from insured individuals) provided by Colorado hospitals, on a cost basis, to be $375.2 million. When physicians and other providers are included, the total rises to $777.1 million in uncompensated charity care.[14]

Lewin estimates that about 40 percent of the hospital shortfall is passed along to payers through the cost shift.[15]

(Readers are encouraged to refer to Lewin's report, "Health spending in Colorado", contained in the "Technical Assessment of Health Reform Proposals" in Appendix 1, for additional analysis of this and other health spending considerations.)

Chapter 6: Health Reform Proposals

Submitted Proposals

In response to its March request for comprehensive health reform proposals, the Commission received 31 proposals. Twenty-eight of those met the requirements of the Solicitation for Health Care Reform Proposals. Of those 28, 23 were considered "comprehensive" (the others addressed discrete issues such as telemedicine, prescription reform, quality assurance and end-of-life care).

Common strategies were found in many of the proposals, as shown below.

Access Strategies

- Increase use of Medicaid managed care (3 proposals)
- Increase Medicaid provider reimbursement (5 proposals)
- Preserve the safety net for those not covered by new programs (2 proposals)

Coverage Strategies

- Expand Medicaid and CHP+ (5 proposals)
- Replace Medicaid with voucher system (3 proposals)
- Subsidize purchase of private insurance (8 proposals)
- Require employers to offer health insurance to their workers or pay a fee (4 proposals)
- Require Coloradoans to have health insurance (11 proposals)
- Reform the individual insurance market (6 proposals)

[13] ADD DEFINITION OF "CHARGES" ON CHART ABOVE
[14] Ibid.
[15] Ibid.

- Create single-payer system that covers everyone (6 proposals)

Benefit Strategies

- Employ a limited benefit package (4 proposals)
- Employ a comprehensive benefit package (13 proposals)

Quality Strategies

- Increase use of health information technology (12 proposals)
- Increase use of evidence-based medicine (8 proposals)
- Pay providers based on outcomes (9 proposals)
- Publish cost and quality information for insurers and providers (10 proposals)
- Increase use of case management (2 proposals)

Cost-Reduction Strategies

- Increase purchasing power by pooling multiple purchasers (3 proposals)
- Reduce administrative costs by creating a single-payer system (6 proposals)
- Increase use of home and community-based services in Medicaid (2 proposals)

Prevention Promotion Strategies

- Provide incentives for healthy behaviors and use of preventive care (7 proposals)
- Require coverage of preventive care (15 proposals)

Selected Proposals

Commissioners reviewed all proposals and, over the course of three meetings in May, narrowed them down, first to an interim list of 11 and then to a final selection of four.

Because SB 06-208 limits the Commission to evaluating no more than five proposals, commissioners decided to analyze just four of those submitted, wishing to leave themselves the option of developing a fifth proposal after seeing the evaluations of the others.

The four proposals selected for evaluation were:

- **Better Health Care for Colorado**, submitted by the Service Employees International Union
- **Solutions for a Healthy Colorado**, submitted by the Colorado State Association of Health Underwriters
- **A Plan for Covering Coloradans**, submitted by the Committee for Colorado Health Care Solutions
- **Colorado Health Services Program**, submitted by the Health Care for All Colorado Coalition

In choosing this slate, commissioners sought to illustrate a range of philosophical beliefs about health reform. The approaches represent a continuum, from Proposal 1, which makes the fewest changes to the existing health care system, through Proposal 4, which would establish a single-payer system.

During the selection process, commissioners recognized that each of the 31 proposals contained important and intriguing ideas. They established a "parking lot" of such ideas from the proposals that were not selected for evaluation, for reference in developing the fifth proposal and the final recommendations.

From June–August 2007, The Lewin Group conducted at least three rounds of modeling analysis on each of the four selected proposals, briefing commissioners on each stage of findings.

Fifth Proposal

The Commission began developing its own fifth proposal in July, establishing a committee (whose meetings all commissioners were encouraged to attend) to spearhead the process. The Fifth Proposal Committee drafted recommendations which were then discussed and voted upon the full Commission.

In developing the fifth proposal, the committee referred to the modeling results of the four selected proposals and the "parking lot" of ideas from all proposals submitted to the Commission. Commissioners also submitted their own ideas for consideration, and the Advisory Task Forces were asked to provide specific input on some of the ideas being considered for inclusion in the proposal.

The Lewin Group analyzed the fifth proposal using the same assumptions as those applied to the other four that were evaluated.

Elements and Analyses of Five Proposals

Overviews of key elements in all five evaluated proposals are provided on the next pages, followed by comparison tables providing side-by-side highlights of their associated impacts on health care costs and coverage. (NOTE: These are high-level summaries. Detailed specifications for each proposal are available in Appendix 2. The Lewin Group's complete analysis of all proposals is available in Appendix 1. Readers are strongly encouraged to review that analysis, which provides essential detail for an adequate understanding of each proposal.)

Better Health Care for Colorado: Submitted by the Service Employees International Union

Key elements

- No requirements for individuals to purchase or employers to provide insurance
- Expands Child Health Plan Plus (CHP+) to 300% of the federal poverty level (FPL)
- Provides private insurance coverage for "working poor" adults
  - Choice of plans offered through health insurance exchange (i.e., a "one stop shop" that offers information, guidance and education to help consumers make informed choices)
  - Offers subsidies for private insurance purchase to parents and childless adults up to 300% FPL
  - Individuals may use subsidy to purchase employer-sponsored insurance
- Uninsured workers who earn above 300% FPL and small businesses that do not offer health insurance can purchase coverage through the exchange without a subsidy
- All plans offered through the exchange must provide at least a "core" minimum benefits package
  - Annual benefit maximum = $35,000
  - Monthly premium cannot exceed $150-250 depending on income
  - Modified community rating for the minimum benefit package
  - No deductible
  - Cap annual benefits at $35,000
- Medicaid reform
  - Medicaid managed care; Primary Care Case Management in rural areas
  - Pay-for-performance for Medicaid hospitals and Medicaid long-term care facilities
  - Consumer-directed home care for Medicaid recipients
- Long-term care reforms
  - Increased access to home and community-based services for people with disabilities and seniors
  - Achieve cost savings through placing recipients in least restrictive settings
  - Improves home and community-based workforce to meet growing needs of consumers

Solutions for a Healthy Colorado: Submitted by the Colorado State Association of Health Underwriters

Key elements

- All Coloradans required to have insurance. Those with insurance get income tax credit; those without pay tax penalty
- Core limited benefit plan for individual insurance
  - All carriers must offer core benefit plan
  - Annual benefit maximum of $50,000
  - Guaranteed issue
  - Limited health status rating
- Subsidies for those up to 250% FPL
- Expands CHP+
  - Covers children up to 250% FPL
- Expands Medicaid
  - Covers parents up to 100% FPL
- In addition to employer-sponsored plans, individuals will have a choice of plans offered through health insurance connector (see "exchange" definition above)
- Any benefit mandate that affects less than 1% of the population and contributes more than 1% of the cost of claims would be eliminated
- Establishes reinsurance pool to cover cost of high-dollar claims (>$100,000)
- Uniform/standardized payments to providers
- Reforms medical malpractice laws, including limits on non-economic damages

A Plan for Covering Coloradans: Submitted by the Committee for Colorado Health Care Solutions

Key elements

- All Coloradans required to have insurance or pay assessment through income tax filing if they do not
- All employers required to either contribute to employee coverage or pay assessment
- Merge individual and small business purchasers into one pool
  - Require guaranteed issue, pure community rating for plans offered through the pool
- Subsidies for those up to 400% FPL
  - Safety net providers must be included in subsidy program
- Minimum benefit package
  - Comprehensive coverage (including dental, mental health, substance abuse, prescription drugs, other benefits)
  - Standardized benefit plans to allow consumers to compare plans
- Expand public programs for disabled (buy-in for those up to 300% FPL), elderly (up to 100% FPL), medically needy (50% FPL), children and parents (up to 300% FPL) and childless adults (up to 100% FPL); merge Medicaid and CHP+

Colorado Health Services Program: Proposed by the Health Care for All Colorado Coalition

Key elements

- Single-payer program governed and administered like a public trust
  - Governing board sets annual budget and determines provider rates
  - Create Colorado Health Trust insulated from general state budget
  - Index funding to rate of growth (e.g., GDP)
- Funded through income tax and payroll deductions
  - Employers may pay for employees
- Covers everyone who has lived in the state at least 3 months, including those enrolled in federal programs such as Medicare, TRICARE, FEHBP, etc.
- Basic benefit package for all based on current Medicaid benefits
  - Cover primary care, hospitalization, lab, emergency, auto and workers' comp, mental health, substance abuse, dental and other benefits; eventually add long-term care
  - Long-term care (room and board excluded for higher income)
  - Minimal co-pays assessed for services
- Statewide patient health information network for cost, utilization and quality information
  - Use data to reward providers for high-quality care and identify and fund training needs

Fifth Proposal: Proposed by the Blue Ribbon Commission for Health Care Reform

Key elements

- Individual mandate – all Coloradans must have insurance or pay assessment through income tax filing if they do not
- Employers not required to offer insurance
  - Required to offer payroll deduction/pre-tax plans to help employees to purchase insurance themselves
- "Connector" for individuals and small employers to purchase insurance
- Reform individual insurance market
  - "Healthy" people can't be turned down
  - Premiums can vary by age, geography
  - Equivalent coverage for mental and physical health
  - Expand Cover Colorado to cover more people with chronic conditions
- Subsidies up to 400% FPL
  - Subsidies for purchase of basic benefit plan
  - Catastrophic care fund for those eligible for subsidy
- Combine and expand Medicaid/CHP+
  - Cover children up to 250% FPL
  - Cover parents and childless adults up to 205% FPL
  - Buy-in program for disabled
  - "Medically Needy" and "Medically Correctable" programs
  - Increase funding for home and community-based service waiver programs
- Optional "Continuous Coverage Portable Plan" similar to Medicare
- 24-hour coverage option for employers

Changes in Sources of Coverage for Coloradoans in 2007-08 (thousands)

	Public Coverage	Employer Insurance	Private Non-Group	Uninsured
Coverage Under Current Policy				
	977.4	2,691.7	158.9	791.8
Changes in Coverage Under Proposals				
"Better Health Care for Colorado" (No mandate: Subsidies below 300% FPL; Limited core benefit)	66.1	(43.9)	302.6	(324.6)
"Solutions for Healthy Colorado" (Individual mandate: Subsidies below 250% FPL; limited core benefit)	114.4	84.5	454.7	(658.4)
"A Plan for Covering Coloradans" (Individual mandate: Subsidies below 400% FPL; comprehensive benefits)	475.7	(28.3)	236.4	(683.2)
"Colorado Health Services Program (CHSP)" (Single payer: Tax financed; comprehensive benefits)	3,642.5	(2,691.7)	(158.9)	(791.8)
Option Number 5 (Individual Mandate: Subsidies <400% FPL)	484.3	(44.1)	230.1	(694.3)

The LEWIN GROUP an INGENIX company

441556

 12

Program Costs and Revenues Under Health Reform Options (millions)

	Total Program Costs	Funding Source				
		Offsets to Current State Spending	Federal Funds: Non-Waiver Dependent	Federal Funds: Waiver Dependent	Specified New Revenues	Unspecified Revenue Requirement
"Better Health Care for Colorado" (No mandate: Subsidies < 300% FPL)	$980	$31	$74	$486	$336	$53
"Solutions for a Healthy Colorado" (Individual mandate: Subsidies < 250% FPL)	$1,366	$179	$280	$54	$853	--
"A Plan for Covering Coloradans" (Individual mandate: Subsidies < 400% FPL)	$3,146	$191	$607	$334	$2,014	--
"Colorado Health Services Program (CHSP)" (Single payer: Tax financed)	$26,578	$3,128	--	$8,425	$15,025	--
Option Number 5 (individual Mandate: Subsidies < 400% FPL)	$2,686	$179	$312	$954	$1,241	--

The LEWIN GROUP an INGENIX company

441556

 13

"Target Efficiency" Measures of Coverage for the Uninsured Under Reform Proposals

	Percent of Uninsured who Become Covered	Number Remaining Uninsured (thousands)	New Program Spending (Millions)	Percent of Funds Going to Currently Uninsured	Program Spending per Newly Insured Person
"Better Health Care for Colorado" (No mandate: Subsidies below 300% FPL)	41.0%	467.2	$980	68.4%	$3,015
"Solutions for a Healthy Colorado" (Individual mandate: Subsidies below 250% FPL)	82.5%	138.4	$1,366	36.5%	$2,091
"A Plan for Covering Coloradans" (Individual mandate: Subsidies below 400% FPL)	86.3%	108.6	$3,146	65.7%	$4,605
"Colorado Health Services Program (CHSP)" (Single payer: Tax financed)	100.0%	--	$26,578	n/a	n/a
Option Number 5 (individual Mandate: Subsidies < 400% FPL)	87.6%	97.5	$2,686	73.3%	$3,868

The LEWIN GROUP an INGENIX company

441556

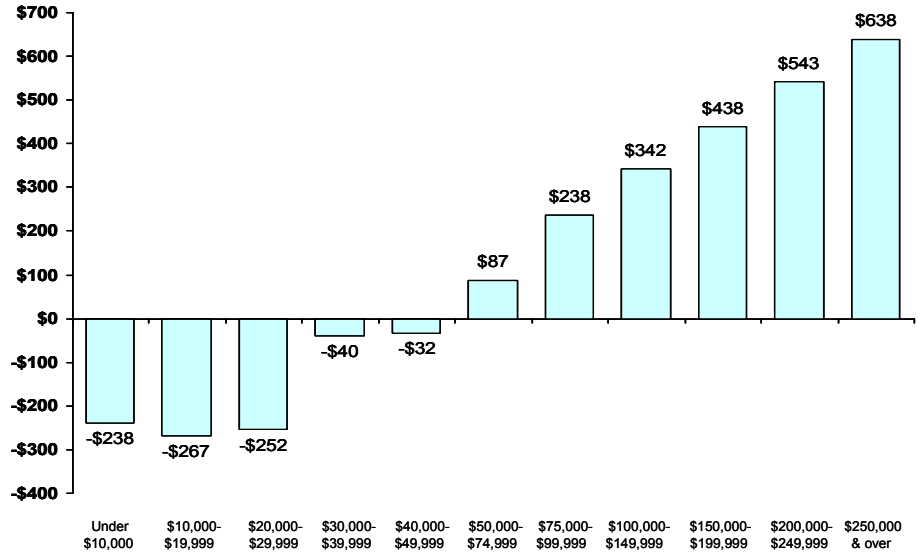
Changes in Statewide Health Spending under Five Health Reform Proposals for Colorado in 2007/2008 (millions)

	Better Health Care for Colorado	Solutions for a Healthy Colorado	A Plan for Covering Coloradans	Colorado Health Services Program (CHSP)	Option Number 5
Statewide Health Spending Under Current Law	$30,100	$30,100	$30,100	$30,100	$30,100
Changes in Health Service Utilization	**$374**	**$781**	**$868**	**$1,774**	**$826**
Utilization for Newly Insured	$374	$781	$868	$1,009	$826
Long-term Care Utilization	-- [a/]	--	--	$765	--
Changes in Provider Reimbursement	**$65**	**($558)**	**$412**	**$0**	**$137**
Reduced Uncompensated Care	$109	$203	$226	$682	$240
Provider Reimbursement Levels	--	($761)	$462	--	($11)
Increase/Reduction in Cost-shift	($44) [b/]	n/a [c/]	($276) [b/]	($682) [d/]	(92)
Changes in Administration	**$164**	**$81**	**$65**	**($2,847)**	**($66)**
Insurer and Program Administration	$164	$81	$65	($1,856)	$100
Provider Administration	--	--	--	($991)	($166)
Bulk Purchasing	**($8)**	**--**	**--**	**$322**	**--**
Prescription Drugs	($8)	--	--	$290	--
Medical Equipment	--	--	--	$32	--
Other Provisions	**--**	**($33)**	**($56)**	**--**	**--**
Net Change in Statewide Health Spending	**$595**	**$271**	**$1,289**	**($1,395)**	**$987**

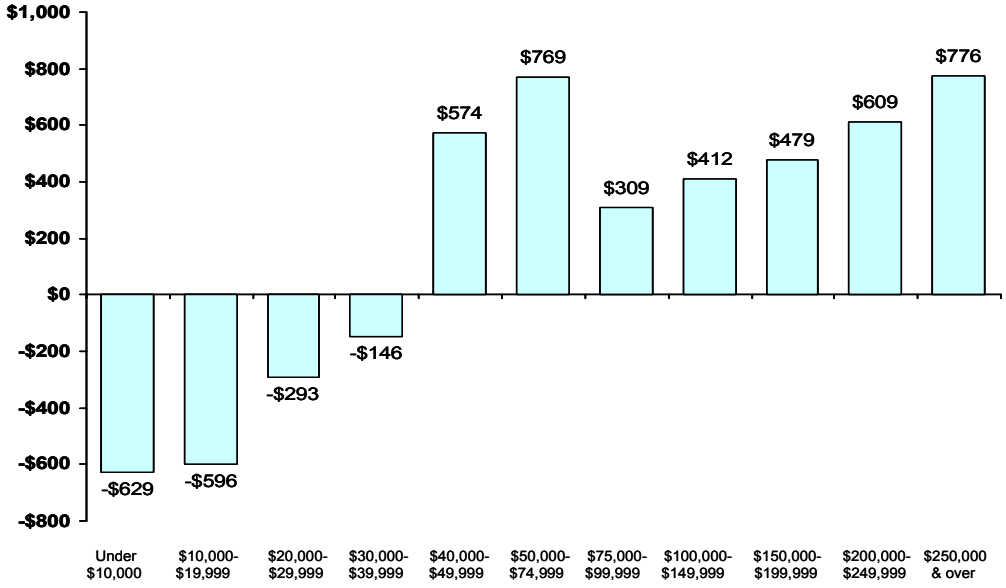
The LEWIN GROUP an INGENIX company

441556

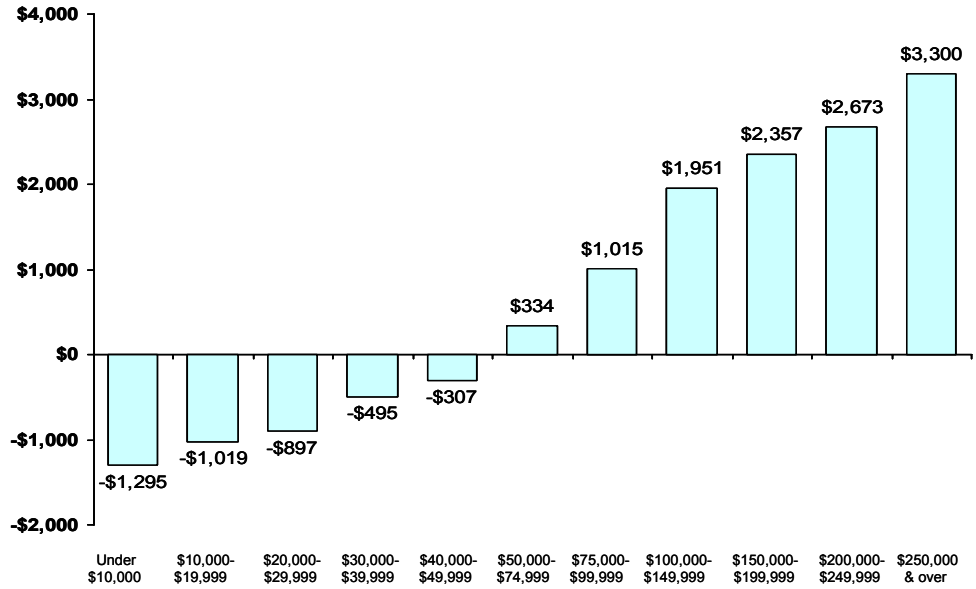
Change in Average Family Health Spending by Income Group under Better Health Care for Colorado in 2007/2008



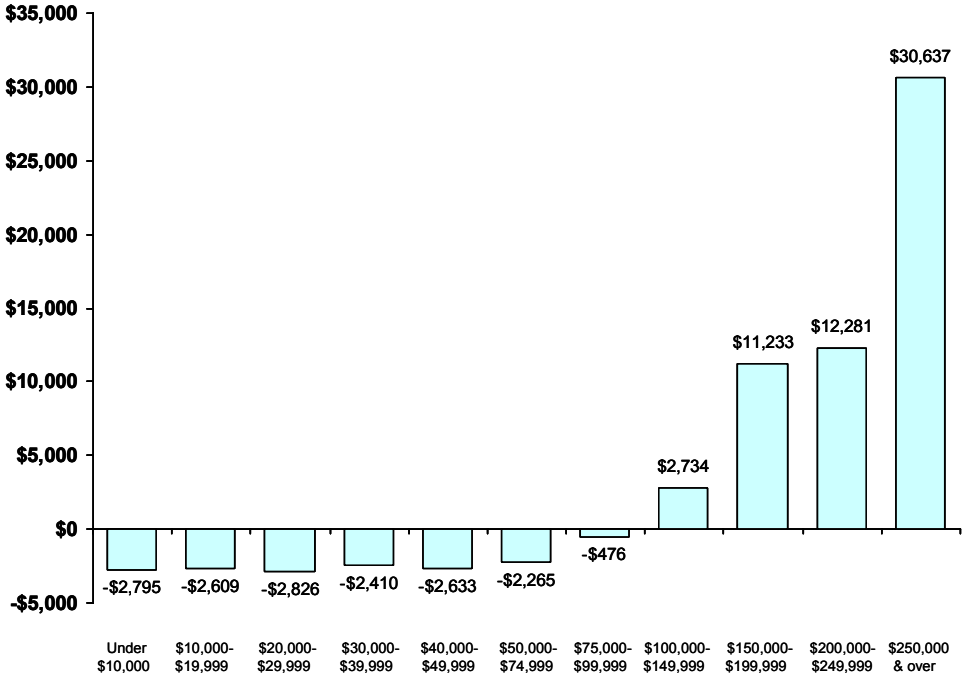
Change in Average Family Health Spending by Income Group under Solutions for a Healthy Colorado in 2007/2008



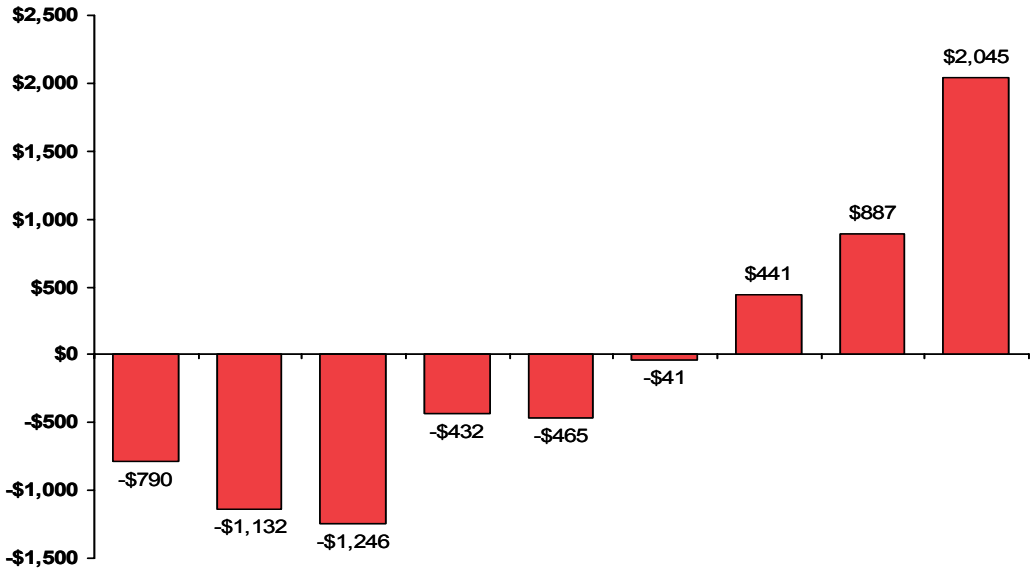
Change in Average Family Health Spending by Income Group under A Plan for Covering Coloradans in 2007/2008



Change in Average Family Health Spending by Income Group under the CSHP Single Payer in 2007/2008



Change in Average Family Health Spending by Income Group under the Commission Proposal in 2007/2008



As part of the modeling process, Lewin required that all five proposals identify mechanisms to finance their suggested reforms. Those suggested funding mechanisms and their estimated impact are shown below for informational purposes only; the Commission makes no recommendations about financing.

New Taxes Created under the Five Health Reform Proposals

	Better Health Care for Colorado	Solutions for a Healthy Colorado	A Plan for Covering Coloradans	Colorado Health Services Program (CHSP)	Option Number 5
Tobacco Tax Increase ($2.00 per pack)	$210 million	$210 million	$210 million	$210 million	$210 million
Alcohol Tax Increase (47 percent increase)	$126 million	$126 million	$126 million	$126 million	$126 million
Tax on Low Nutrition Foods	--	$522 million	--	--	$41 million
Premium Tax	--	--	$240 million (5.8 percent)	--	--
Provider Tax	--	--	$688 million (3.1 percent)	--	--
Employer Payroll Tax	--	--	--	$6.5 billion (6.0 percent of payroll)	--
Increase State Income Tax Rate (currently 4.6%)	--	--	$571 million (0.6 percentage points)	$8.2 billion (8.1 percentage points)	$864.2 million (0.8 percentage points)
Employer Assessment of per $347 non-covered FTE	--	--	$179 million	--	--

The Lewin Group an INGENIX company

441556

Chapter 7: Recommendations to the General Assembly

Introduction

Lewin's baseline analysis of health coverage and spending in Colorado, highlighted in Chapter 5m provided powerful information to the Commission about where to target policy interventions. For example:

- Most of the uninsured work. About 37.5 percent of Colorado's uninsured are workers and dependents associated with firms that do not offer coverage to any of their workforce; close to 21 percent of the uninsured are ineligible for the coverage offered by their employers. While individual coverage is available to such individuals, many choose not to buy it – and many others cannot afford it because of health conditions. *What can be done to encourage employers to facilitate access to insurance for their workers, and to make individual coverage more accessible and affordable?*
- At the same time, approximately 11 percent of Colorado's uninsured are eligible for employer-sponsored coverage but decline it. And, viewing the uninsured population another way, about 13 percent have incomes over $75,000 annually; 6.5 percent of the uninsured earn more than $100,000 a year. We can infer that the majority of these uninsured are healthy and have chosen to forego coverage because they believe they do not need it and choose to spend their money elsewhere. *How can we bring these healthy Coloradans into the insurance pool?*
- Approximately 24 percent of Colorado's uninsured live below the federal poverty level (i.e., they are in households earning less than $20,000 annually). But, under current Colorado law, adults without children are not eligible for Medicaid unless they are aged and disabled, and then only at even lower income limits; parents of children enrolled in Medicaid can only qualify for the program if they earn less than 66 percent of the federal poverty level, or less than about $13,200 annually. *What can we do to simplify and expand public coverage in our state to meet the needs of the most vulnerable among us? In light of low reimbursements to providers who participate in Medicaid and CHP+, how can we raise those payments and encourage participation, in order to handle greater numbers of enrollees in these programs?*

These trends carry implications for costs as well as coverage. When we bring more healthy people into the insurance pool, it lowers the risk and thus the costs for everyone else. When we extend health coverage to more people, we minimize the cost shift from uncompensated care that contributes to escalating health insurance premiums.

As the Commission debated how best to address these issues in its recommendations, certain imperatives emerged:

- Everyone – individuals, employers, providers, insurers and the government – has a role to play in addressing Colorado's health care needs. All have a share in the responsibility; all will share in the benefits.

- "One size fits all" doesn't work in health care. People have differing income levels and health care needs, and health status can change in an instant. We need a range of interventions that respond to such differing needs.
- Some people simply cannot afford private insurance coverage. Those people ought to have access to public coverage for basic health care needs.
- Individuals should have meaningful choices and options that give them control over their own care and coverage decisions.
- Government, through the public health system and public insurance programs, can promote and encourage healthy lifestyles and preventive care. Individuals, however, have responsibility for their own health and wellness.
- We seek to build on the strengths of the current system, keeping and broadening what works to minimize dislocation for those who already have good coverage, while making important changes to better meet the needs of those who currently lack affordable health coverage.
- In order to accomplish our goals, we must maximize the federal funding available to Colorado – for example, through public program expansions that will enable us to draw down the maximum federal match, and through applications for federal waivers that will enable us to try new approaches to better meet the needs of Colorado's vulnerable populations.

The recommendations that follow draw upon the Commission's "Guiding Principles" (described in Chapter 2), the analysis of all five proposals, learnings from other states and health policy experts, the counsel of the Commission's Advisory Task Forces and the input received from the public at meetings statewide. They fulfill the Commission's statutory charge to study and establish health care reform models that expand health care coverage and decrease health care costs for Colorado residents.

As a reflection of the Commission's twin charges, these recommendations fall largely into two groupings:

- Strategies for reducing health care costs, while enhancing quality of care
- Strategies for increasing access to care, stressing consumer choice

What follows is not merely a laundry list of recommendations. It is a comprehensive, integrated package that will only succeed in fulfilling its promise if viewed and adopted as a whole.

Equally important is the staging of these recommendations. While the package should be viewed as a whole, it should not be enacted "in one fell swoop." There are essential building blocks among these recommendations that must be put in place before others, if those latter elements are to be successful. Readers will find specific suggestions about implementation timing in Part 3 of the recommendations.

Taken together, our recommendations offer a bold yet realistic approach to providing high quality, affordable health care to all Coloradans.

PART 1: Reduce Health Care Costs, while Enhancing Quality of Care

1) Slow the rate of growth of employer and private health insurance premiums by covering the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing cost-shifting.

Rationale

According to one study, 8% of the cost of health insurance premiums in Colorado is due to cost-shifting.[16] Cost-shifting occurs when health care providers charge privately-insured patients more for services, in order to make up free care provided to the uninsured or care provided for less than cost for Medicare and Medicaid patients. Earlier discussion in this report described the extent to which Colorado hospitals charge privately-insured patients more, to make up for care provided to uninsured and publicly-insured patients. The Commission believes, therefore, that its recommendations to cover the uninsured and improve Medicaid reimbursement rates could significantly reduce the rate of growth of health insurance premiums that employers, employees and individuals pay in Colorado.

Recommendations

a) **Reduce uncompensated care by covering at least 85% of the uninsured in Colorado.** The recommendations in Part 3 cover 88% of the uninsured in Colorado, thereby significantly reducing the number of uninsured patients seen by Colorado health care providers. In addition, 40% of these newly-insured Coloradans would be covered by employer or private health insurance.

b) **Reduce cost-shifting by increasing Medicaid provider reimbursements (See Recommendation 22).** The recommendations in Part 3 suggest that Medicaid provider reimbursements be increased to the rates used by the Child Health Plan Plus program (approximately 80% of Medicare for physicians and 65% of billed charges for hospitals[17]). This increase in provider reimbursement rates will reduce cost-shifting from publicly- to privately-insured Coloradans and is especially important as the number of publicly-insured Coloradans grows.

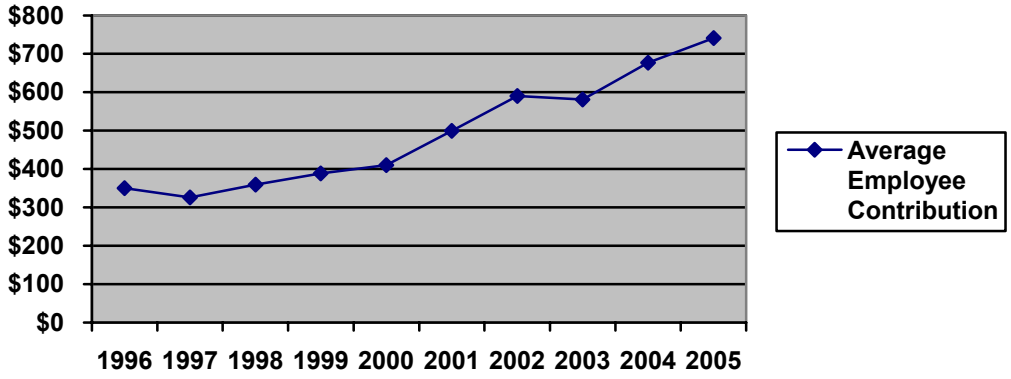
2) Reduce employee premiums for health insurance.

[16] Families USA. Paying a Premium: The Added Cost of Care for the Uninsured. June 2005.
[17] These reimbursements are used in the CHP+ managed fee-for-service network.

Rationale

Despite the number of people covered by employer plans in Colorado, a growing number of employees are declining their employer-sponsored insurance due to the rising cost. The following table shows that the average total employee contribution for single coverage in Colorado increased by more than 100% between 1996 and 2004:

- Figure 1 Average total employee contribution per enrolled employee for single coverage at private-sector establishments that offer health insurance: Colorado



Source: Agency for Healthcare Research and Quality. Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and State (Colorado) (Table II.C.2), years 1996-2005: Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 02, 2007)

Recommendations

To increase affordability of employer health coverage, the Commission is recommending that Colorado implement two strategies: require that all Colorado employers offer their employees the opportunity to purchase health insurance with pre-tax dollars; and provide subsidies for low-income uninsured workers to purchase their employer's health plan.

a) **Require Colorado employers to establish at least a Section 125 premium-only plan that allows employees to purchase health insurance with pre-tax dollars** (See Recommendation 17a). For employees with access to employer coverage, the ability to purchase coverage on a pre-tax basis can reduce the cost of coverage by as much as 40 percent. The Lewin Group estimates that Coloradans would save $372.9 million on their federal taxes through the use of 125 plans. This recommendation was also endorsed by the Commission's Business Advisory Task Force as a reasonable way to increase affordability of coverage for Colorado employees.

b) **Provide subsidies for uninsured low-income workers below 400% FPL to purchase their employer's plan**. (See Recommendation 17b). Providing premium assistance to low-income workers was included in almost half of the health care reform proposals received by the Commission. Premium subsidies for low-income uninsured workers allow individuals and

their families to enroll in private, employer-based coverage. The Commission recommends that employees that earn less than 300% of poverty be given subsidies equal to 80-100 percent of their employer's total premium, minus their employer's contribution to their coverage. For employees earning up to 400% of poverty, the Commission recommends that they be eligible for a subsidy that would reduce the cost of the Minimum Benefit Plan (see Recommendation 17 for a description of the Minimum Benefit Plan) to no more than 9% of their annual income—a subsidy that could be used to purchase their employer's health plan. According to The Lewin Group, such subsidy programs would allow 19,700 low-income uninsured workers in Colorado to enroll in their employer's plan.[18]

3) Reduce administrative costs.

Rationale

With at least 36 licensed health insurance companies in Colorado, the administrative burden on physicians and other providers to seek reimbursement for their health care services can be significant. To reduce these costs, the Commission recommends that Colorado require health plans to standardize functions that affect physicians and other providers.

Recommendations

a) **Require health insurers and encourage all payers in Colorado to use standard claims attachment requirements, eligibility and coverage verification systems, standard electronic ID cards, standard prior authorization procedures, and uniform insurance application forms**. This recommendation builds on a recommendation of the Commission's Provider Task Force to "standardize claims and payment process across health plans to . . . minimize administrative costs." The Lewin Group estimates that standardizing health plan administrative claims and processes will reduce administrative costs for Colorado providers by $166 million annually.

b) **Combine administrative functions of public health insurance programs.** Where possible, the Commission recommends that Colorado combine administrative functions, such as eligibility determination, marketing, plan and provider contracting, and claims payments for its public health insurance programs, such as the new premium subsidy program, the new Connector, and CoverColorado. See "State Administrative Functions" Appendix for a table listing new and existing programs and their common administrative functions.

c) **Review regulatory requirements on third-party payers and providers with the goal of reducing administrative burden.** State insurance regulation may be outdated and in need of reform, especially in light of the Commission recommendations to encourage enrollment in private health insurance in Colorado. The Commission recommends that the state undertake a review of all existing insurance law and regulations to evaluate options for reducing unnecessary administrative burden on insurance companies doing business in Colorado.

4) Increase use of prevention and chronic care management.

[18] To further facilitate enrollment in employer coverage, the Commission recommends that qualifying for a subsidy be a qualifying event for enrollment in employer coverage. See Appendix X Recommendations to the Federal Government

Rationale

Promoting prevention and wellness was one of the recommendations most often heard by the Commission as it solicited health care reform proposals, received recommendations from advisory task forces, and conducted public hearings. Over one-half of the proposals received by the Commission proposed methods for increasing use of preventive care or incentivizing personal wellness. Each of the four advisory task forces of the Commission—Business, Provider, Rural, and Vulnerable Populations—recommended strategies for increasing prevention and wellness in employer, medical, and community settings. Citizens across the state who attended the Commission's public hearings said that they wanted people to take ownership of their own health by living healthy lifestyles and seeking out preventive care.

Recommendations

a) **Where allowed by HIPAA, allow health insurance premiums to be reduced for enrollees who engage in healthy behaviors**. A strategy recommended in several of the health care reform proposals it received, the Commission recommends that heath insurance premiums be reduced for enrollees who engage in healthy behaviors. Although federal law places restrictions on the extent to which such discounts can be given, the Commission believes that those who engage in behaviors that improve health should pay less for their health insurance.

b) **Eliminate patient copayments for preventive care and reduce patient copayments for chronic care management services** as defined by nationally-recognized, Colorado-vetted uniform guidelines, such as those developed by the Colorado Clinical Guidelines Collaborative. The Commission's Vulnerable Populations Task Force recommends that copayments for evidence-based preventive care be eliminated. The Commission builds on this recommendation by recommending the elimination of copayments for evidence-based preventive care and the reduction of copayments for chronic care management.

c) **Encourage employers to provide workplace wellness programs**. The Commission's Business Task Force states in its report to the Commission that Colorado "businesses are willing to play a role in employee education around healthy lifestyles." The Commission agrees, and recommends that Colorado employers, including the State of Colorado, be encouraged to provide workplace wellness programs for their employees.

d) **Encourage individual responsibility for health, wellness and preventive behavior**. The Commission heard from proposal authors, task force members and the public that personal responsibility is an essential component of health care reform. At public hearings across the state, citizens testified that people need to take ownership for their own health. The Commission's Vulnerable Populations Task Force recommends that Colorado focus on incentivizing consumers to engage in healthy behaviors and use appropriate preventive care. And over 25% of health care reform proposals received by the Commission included incentives for consumers to engage in healthy behaviors and use appropriate preventive health care services.

e) **Increase funding for local public health agencies in Colorado to perform functions such as preventing disease and injury, assessing community health, and promoting healthy behavior**. The Rural Task Force agreed on the importance of wellness and prevention for

health care reform. It recommends that funding for public health be increased to assure the Colorado local health departments and nursing services have adequate funding to preventive disease and therefore contain health care costs, especially in rural Colorado.

5) Conduct a comprehensive review of current Colorado long-term care information

Rationale

The importance of long-term care cannot be overlooked given its potential fiscal impact on the state's Medicaid budget and is paramount significant to Coloradans with severe chronic conditions. The Commission had very limited time and the complexity of this matter made it impossible for the Commission to specifically and adequately address this topic. Long-term care in Colorado has been recently studied by groups such as the Senate Bill 173 Commission and the Developmental Disabilities Interim Committee. It is the reports and recommendations of these groups that the Commission recommends be reviewed for consideration and action in conjunction with health care reform as it relates to long-term care.

Recommendation

a) **Conduct a comprehensive review of current Colorado long-term care information** as a supplement to any review of the Commission reports with the goal of:

- Requiring consumer control, governance and accountability by those served
- Serving all persons needing long term care services
- Ensuring the highest possible quality of care is provided in the least restrictive setting available
- Protecting the fiscal integrity of the long-term care system

6) Improve end-of-life care.

Rationale

Similarly to long-term care, the Commission believes that improvements in end-of-life care, particularly palliative and hospice care, are essential to giving Colorado's aging population more control of the type and amount of health care they receive. The Commission also received a proposal that identified strategies for improving end-of-life care, such as launching a public awareness campaign about hospice, dying and death; guaranteeing the option for arranging for death outside of hospital or other institution, and amending the Colorado Statutes for physician licensure to include a requirement for palliative and end-of-life treatment and care.

Recommendations

a) **Develop strategies to foster clinically, ethically, and culturally appropriate end-of-life care, including palliative and hospice care, based upon best scientific evidence**.

b) **Ask patients, upon entry to a nursing home, home health, or other critical point of access, to complete an advanced directive**. There would be no requirement to complete an advanced

directive, patients would be fully informed, there would be no outside pressure to complete the form, and revocation rights would be clear and simple.

7) **Commission an independent study to explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training.**

Rationale

The Rural Task Force recommends the expansion of scope of practice for non-physician health care professionals, as midlevel providers can substantively improve health care access in rural areas. The Provider Task Force recommends that licensure and scope of practice should balance assuring quality of care with the need to maximize provider capacity. The Commission recognizes the important of expanding access to care for current residents of underserved areas as well as Coloradans who will become insured under health care reform, while simultaneously assuring quality of care.

Recommendations

a) **Commission an independent study to explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training.** The Commission recommendations that Colorado examine ways in which non-physician providers can appropriately provide needed access to care in underserved areas of the state.

8) Provide a medical home for all Coloradans.

> Resources must be committed to re-engineer an aligned, cohesive, and coordinated system that supports a primary care-based "healthcare home" as the cornerstone of care.
>
> --The Provider Task Force of the Blue Ribbon Commission for Health Care Reform

Rationale

The next set of recommendations address issues such as medical homes, health information technology, evidence-based medicine, provider reimbursement based on quality, health care transparency, and consumer choice. These recommendations together attempt to address what the Provider Task Force termed a "lack of systemness" in Colorado's health care system. The Commission agrees with the Provider Task Force that system-wide changes must happen in health care delivery in Colorado to improve quality and "flatten the trend" of health care spending growth. Many health care reform proposals recommended these changes as well. Over one-third of the proposals received by the Commission recommended systematic changes to Colorado's health care system such as increasing use of information technology and promoting transparency of health care costs and quality.

"Systemness" begins with every Coloradoan having a medical home. "Medical home" is a source of usual care, such as a physician or clinic, selected by a patient. The medical home

functions as the central point for coordinating care around the patient's needs and preferences. The medical home also coordinates between various team members, which include the patient, family members, specialists, other healthcare services, and non-clinical services.[19] With a medical home in place, other system improvements, such as health information technology and evidence-based medicine, become more effective.

Recommendations

a) **Provide a medical home for all Coloradans, and enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs**." Patient-centered care is an important element of the medical home.

b) **Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and CoverColorado programs**. The Commission believes that medical homes are particularly important for vulnerable populations, such as those served by Medicaid and CoverColorado. The Commission recommends that providers in these programs be reimbursed for providing care coordination and case management to their high-needs patients.

9) Support the adoption of health information technology.

Rationale

Another important aspect of creating an integrated health care system in Colorado is the expansion of the use of health information technology, particularly electronic health records and interoperable state health information networks. Over 40% of health reform proposals received by the Commission suggested expanding and implementing health information technology to improve the cost and quality of health care delivered in Colorado. In addition, three of the four advisory task forces of the Commission (Business, Provider, and Vulnerable Populations) recommended increased use of health information technology to support medical homes, seamless care, reduction of medical errors, and elimination of duplication of services.

Recommendations

a) **Support the creation of a statewide health information network, focusing on interoperability.** Several health care reform proposals received by the Commission recommended expanding the ability of health care providers in the state to electronically communicate patient information by creating a statewide health information network. The Commission agrees with the Provider Task Force that these efforts should build on existing local and state efforts in Colorado such as the North Colorado Health Alliance, the Pikes Peak Region initiative, and the Mesa County initiative. Several proposals also suggested building upon the statewide efforts of the Colorado Health Information Exchange (COHIE) and the Colorado Regional Health Information Organization (CORHIO).

19 Adopted from the National Quality Forum

b) **Support the creation of an electronic health record for every Coloradan, with protections for patient privacy**. The Provider Task Force recommends that "every primary care practitioner must have tools necessary to track, measure, and coordinate care." The Commission believes that to accomplish this goal as well as to implement the statewide health information network above, every Coloradoan needs an electronic health record that helps patients and providers document and share, with protections for privacy, patient health care information. Such electronic medical records may reduce duplication and medical errors, and enhance care coordination between providers.

10) Support the provision of evidence-based medicine[20].

Rationale

Almost 30% of the health care reform proposals received by the Commission recommend expanding the use of evidence-based medicine in the state, as a method for increasing quality and reducing cost of health care. Strategies described in the proposals include developing care guidelines, using performance measures, and collecting better data on cost and quality of care. The goal of these strategies is to try to apply scientific knowledge about best care more systemically and expeditiously to clinical practice.

Recommendations

a) **Adopt population-specific care guidelines and performance measures, where they exist, based on existing national, evidence-based guidelines and measures, recognizing the importance of patient safety and best care for each patient**. This recommendation attempts to reconcile two inclinations that are sometimes in opposition: to create care guidelines that are consistent with national guidelines developed by organizations such as the American Academy of Pediatrics, while also creating guidelines that are acceptable to Colorado providers and patients. Several proposals recommended that guidelines in Colorado continue to be developed in the manner established by the Colorado Clinical Guidelines Collaborative, which has worked with 50 Colorado health care organizations to develop eight clinical guidelines regarding care for conditions such as asthma, cancer, diabetes, and depression. The Commission recommends the continuation and support of this process for guideline development, recognizing that there is not strong evidence based for all conditions and populations, particularly for patients with multiple chronic conditions.

b) **Develop a statewide system aggregating data from all payer plans, public and private**. The first step to providing consumers better data about the cost and quality of care is to collect data that allows consumers and purchasers to draw statistically significant conclusions about the cost and quality of the care delivered by individual health care providers. To reach this goal, the Commission agrees with the Provider Task Force, as well as the two quality proposals submitted to the Commission by health care quality experts, that a retrospective claims database is the first step toward a system that would measure the efficacy and efficiency of

20 Evidence-based medicine is defined as "A set of principles and methods intended to ensure that, to the greatest extent possible, population-based policies and individual medical decisions are consistent with the evidence of effectiveness and benefit."

care. Such a database could also grow into a system that will help providers make prospective and point-of-care decisions.

11) Pay providers based on quality.

Rationale

Although reimbursement is not the only factor that influences provider behavior, it is an important one. Almost one-third (32%) of proposals received by the Commission recommended paying health care providers based on their performance. Ideas submitted to the Commission included rewarding providers who implement best practices, score high on performance measures, and coordinate care for patients. The Commission believes that changing reimbursement methodologies for health care providers is an important element of creating a health care "system" for Colorado patients.

Recommendations

a) **Pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care, and use of health information technology**. This recommendation builds on the Commission's previous recommendations to implement health information technology, evidence-based medicine, and medical homes in Colorado. Reimbursing providers for engaging in these practices ensures that provider incentives are aligned to create better quality and cost outcomes for patients.

12) Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g. Web site).

Rationale

One of the characteristics of an efficient market is adequate information. Health care has never operated in this fashion. Consumers know something about the cost of their coverage (though not necessarily the full cost, if their employer contributes). But they do not know the real cost of the care provided to them. Nor, as a rule, do they know much about the quality of the care they are about to receive.

Availability of such information is essential to driving down costs and improving quality. Such transparency will enable consumers and employer purchasers to "vote with their feet," encouraging health plans and providers to continue the steps they are already taking to manage costs and improve quality of care. (The Commission recognizes and applauds existing quality reporting efforts, such as the report card on hospital quality that is being developed, the Colorado Business Group on Health's report card and others. We note, however, the need for increased availability of such information and additional reporting efforts. For example, consumers should have access to the precise total costs for specific services provided by health care providers.)

Recommendations

a) **Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point** (e.g. Web site). Over one-third of proposals received by the Commission recommended increasing the transparency of health care cost and quality data by publishing better consumer information. This recommendation builds on the prior recommendations to increase use of heath information technology and evidence-based medicine, which will increase the amount of statistically-reliable information that can be reported to consumers and purchasers on the cost and quality of insurance products and health care services.

b) **Require DOI to report annually to the legislature regarding financial information on licensed carriers and public coverage programs;** information should include medical loss ratios, administrative costs, etc, by line of business. In addition, Medicaid, CHP+, CoverColorado and other public coverage programs should be required to provide DOI with this information. Finally, brokers should be required report their compensation to their clients.

13) Promote consumer choice and direction in the health care system.

> (Health care reform should) decrease complexity of health care plans and provide consumer education in acceptable mediums. (Health care reform should) provide tools that enable consumers to make informed choices
>
> --Vulnerable Populations Task Force of the Blue Ribbon Commission for Health Care Reform

Rationale

The final link in the chain of creating a more integrated and efficient health care system in Colorado is to assure that, in addition to improved consumer information, consumers have choice and control in their health care decisions. The Commission believes that consumers should have choices regarding their health insurance--especially in light of a requirement to buy insurance--and that they should have accurate information with which to make informed choices.

Recommendations

a) **Provide a choice of Minimum Benefit Plans, including a Health Savings Account option, for all consumers purchasing in the individual insurance market** (Recommendation 20). The Minimum Benefit Plan, similar in concept to the existing Standard and Basic Plans in Colorado's small group market, should be varied by insurers to include a Health Savings Account (HSA) option or to reflect an insurer's provider network, such as an HMO or a PPO, thus providing consumers a choice of plans. A standardized plan also enables purchasers of insurance in Colorado to compare prices among various insurance companies.

b) **Create a Connector for individuals and employees** (Recommendation 18). This entity would offer a choice of benefit packages with easily comparable price and quality information. Benefits of a Connector for small businesses and individuals include encouraging competition between health plans and facilitating employee choice of benefit plans.

c) **Increase price and quality transparency** (Recommendation 12). Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g. Web site).

d) **Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care**. In conjunction with the Commission's recommendations on medical homes (Recommendation 8) and evidence-based medicine (Recommendation 10), the Commission recommends that consumers be given evidence-based medical information at the point of service to aid them in decision-making. The Commission believes that improved information from medical providers to patients regarding medical decisions is a powerful mechanism for improving cost and quality of health care in Colorado.

14) Examine and expand the efforts of Colorado communities which have been proven over the years to enhance quality and lower cost.

Rationale

Colorado has several examples of high-quality, cost-effective health care delivery systems. For example, the Dartmouth Atlas study determined that Mesa County provides the most cost-effective delivery of Medicare services for the chronically ill Medicare beneficiaries in the country, cutting the need for hospitalizations from more than 19 days to 6.5 days, and reducing overall per capita spending from $60,000 to $21,000. The Department of Health Care Policy and Financing has determined that the Medicaid program in place in Western Colorado not only has vastly superior quality measurements (immunizing four times as many children, having 95% of pregnant women in prenatal care programs, etc.), but also that the improved quality saves the state millions of dollars per year. The Business Task Force supports the Commission's recommendation to expand successful local efforts, as "local services minimize use of inappropriate services."

Recommendations

a) **Examine and expand the efforts of Colorado communities which have been proven over the years to enhance quality and lower cost**.

15) Create a multi-stakeholder "Improving Value in Health Care Authority"

Rationale

The prior recommendations to improve quality and reduce cost of health care in Colorado need to be studied, and sometimes implemented, by an organization that can work across the health care system to create a vision and consensus for improving Colorado's health care system. The Commission recommends, therefore, that Colorado create an Improving Value in Health Care Commission, to facilitate and/or implement the Commission's recommendations regarding issues such as reduction of administrative costs, improved preventive care, and expansion of consumer information and choice.

Recommendations

a) **Before implementing the coverage expansions identified in Section 3, the state should establish an Improving Value in Health Care Commission to fundamentally realign incentives in the Colorado health care system to reduce costs and improve outcomes.** This multi-stakeholder group would address ways to redesign health insurance benefits, preventive care, provider reimbursement, medical records, and consumer information. Its goal would be to fundamentally realign incentives in the system to reduce costs and improve outcomes. Without such a critical look at these issues, the other recommendations of the Commission will be inadequate to address the health care reform needed to patients and providers in Colorado.

b) **Give the Authority rule-making authority to implement the Commission's recommendations regarding administrative simplification (Recommendation 3), health care transparency (Recommendation 12), design of the Minimum Benefit Package (Recommendation 16b), and the Ombudsman and Advocacy Program (Recommendation 28)**.

c) **Direct the Authority to study and make recommendations to the Governor, state legislature, and rule-making agencies regarding prevention (Recommendation 4), end-of-life (Recommendation 6), medical homes (Recommendation 8), health information technology (Recommendation 9), evidence-based medicine (Recommendation 10), and provider reimbursement (Recommendation 11)**.

d) **The Authority should also be responsible for assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers**. The Commission recommends that the effectiveness of health care reforms be assessed against the criteria developed by the Commission for evaluation of health care reform proposals.[21] The Commission also agrees with the recommendation of the Vulnerable Populations Task Force that health reform efforts should be evaluated to determine their impact on the uninsured and vulnerable populations.

e) **Establish the Authority before embarking on the improvements to coverage and access described in Part 2**.

PART 2: Improve Access to Care, with Mechanisms to Provide Choices

16) Require every legal resident of Colorado to have at least a Minimum Benefit Plan, with provisions to make the mandate enforceable.

> Individual mandates appropriately place responsibility for insurance on individuals rather than the employer.
>
> --Business Task Force of the Blue Ribbon Commission for Health Care Reform

[21] The criteria are comprehensiveness, access, coverage, affordability, portability, benefits, quality, efficiency, consumer choice and empowerment, wellness and prevention, and sustainability

Rationale

The requirement to have health insurance (known as an "individual mandate") is a cornerstone of the Commission's vision for reforming Colorado's health care system. Coupled with the provision of affordable coverage and effective enforcement, the requirement assures that almost all residents of Colorado will come into the health coverage pool. Alternative methods for assuring coverage for all residents, such as single-payer proposals, were viewed by the Commission as being too disruptive of current coverage and also unworkable in a single state. The individual mandate, by contrast, builds on Colorado's existing health care system.

About 40% (11) of the 28 comprehensive health care reform proposals submitted to the Commission included an individual mandate as a key strategy for covering the uninsured, making an individual mandate the most common strategy proposed to the Commission for reducing the number of uninsured in Colorado. Subsequent analysis by The Lewin Group also showed that this strategy could significantly increase the number of Coloradans who have insurance. The implementation of an enforceable mandate increases the number of Coloradans who will purchase individual and employer coverage as well as the number of families who will enroll in public programs. Lewin estimates that the effect of an individual mandate in Colorado would be an additional 106,900 uninsured Coloradans purchasing their employer's health insurance and an additional 45,700 uninsured Coloradans purchasing individual private coverage.

In addition to reducing the number of uninsured Coloradans, an individual mandate would also reduce the premiums paid by those who are currently insured. This is due to the "cost shift" created when hospitals and other providers increase their rates to private insurance companies in order to cover the cost of care provided free or at reduced rates to the uninsured. Colorado health care providers gave $777 million in uncompensated care in 2007.[22] The elimination of free care to the uninsured, therefore, is predicted to reduce the rates that hospitals and other providers would charge to insurance companies, thereby stabilizing rates paid by employers, employee, and individuals for health insurance. The Business Task Force also supports the individual mandate for this reason.

Recommendations

a) **Require purchase of a Minimum Benefit plan (average monthly premium of approximately $200 for an individual).** Twenty percent of the proposals received by the Commission suggested using leaner health insurance packages—with high deductibles, annual caps, or limited benefits—as a mechanism for assuring affordability. While this strategy has the negative consequence of potentially not meeting everyone's needs—i.e., some enrollees will need health care services not covered by a minimum benefit plan—the Commission felt that a minimum benefit package was essential for assuring availability of an affordable product. For

[22] The Lewin Group. Technical Assessment of Health Care Reform Proposals. Appendix B: Health Spending in Colorado. P B-30.

example, minimum benefit plans evaluated by the Commission reduced premiums by 15%-27%.[23]

b) **Design and periodically review the Minimum Benefit Plan through the "Improving Value Authority."** Ensure that the process to create the minimum benefit package is transparent, participatory, equitable, compassionate, sensitive to value, flexible and responsive. The Commission further recommends that its recommendations regarding preventive care (Recommendation 4) and mental health parity (24d) be considered when designing this benefit package.

c) **Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level.** Assuring affordability should include consideration of both premium and out-of-pocket costs.

d) **Enforce the mandate through a tax penalty and enroll those who are eligible for fully-subsidized coverage in that coverage.** The tax penalty would be equal to one year's worth of coverage (minus any subsidies for which the filer is eligible). Those who file without proof of coverage will be contacted for assistance in enrolling in coverage and those who are eligible for fully-subsidized public coverage programs will be automatically enrolled.

17) Implement measures to encourage employees to participate in employer-sponsored coverage.

[23] The Lewin Group. Cost and Coverage Impacts of Four Health Proposals to Reform the Colorado Health Care System, Slide 14: /summary of Benefits under a Typical Commercial Plan and Under the Four Health Reform Proposals. Presentation to the Commission, August 23, 2007.

Rationale

Employer-based health plans currently cover approximately 60 percent of Coloradans[24]. Despite the number of people covered by such plans, a growing number of employees are declining their employer-sponsored insurance due to the rising cost, as noted earlier in this report. By encouraging enrollment in employer-based health insurance, the Commission hopes to retain employers as an important private sector partner in assuring health care coverage for all Coloradans.

Note that the Commission's recommendations regarding employers in Colorado do not include a mandate for employers to offer coverage to their workers. Although several health care reform proposals submitted to the Commission included such a requirement, the Commission ultimately agreed with the Business Task Force as well as public input received during public hearings, that an employer mandate could have a negative impact on business development in the state and be particularly harmful to small businesses. As an alternative, the Commission is recommending a series of strategies aimed to make employer coverage more affordable for employees, therefore increasing voluntary enrollment in this important health insurance option.

Recommendations

a) **Require Colorado employers to establish a premium-only Section 125 plan that allows an employee to purchase health insurance with pre-tax dollars.** (This recommendation was endorsed by the Commission's Employer Advisory Task Force.) For employees with access to employer coverage, the ability to purchase coverage on a pre-tax basis can reduce the cost of coverage by as much as 40 percent. The Lewin Group further estimates that Coloradans would save $372.9 million on their federal taxes through the use of 125 plans. To ease the administrative burden to employers of establishing these plans, the Commission further recommends the State of Colorado implement state rules, allowed by the IRS, which can simplify the 125 plan process for employers. Employers could also have the option to extend this pre-tax benefit to employees who are not eligible for the group plan but have established a "voluntary" individual plan with the Connector (see Access Recommendation 3 below).

b) **Provide subsidies for uninsured low-income workers below 300% FPL to purchase their employer's plan**. This strategy of providing premium assistance to low-income workers was included in almost half of the health care reform proposals received by the Commission. Premium subsidies for low-income workers allow families to enroll in private, employer-based coverage and allow them to comply with the individual mandate without undue financial burden. The Commission recommends that employees be given subsidies equal to 80-100 percent of their employer's total premium, minus their employer's contribution to their coverage. The Commission further recommends that subsidy checks be sent straight to employees, to avoid placing a new administrative burden on employers of processing subsidy

[24] The Lewin Group. Technical Assessment of Health Care Reform Proposals. Appendix A: Characteristics of the Uninsured in Colorado. P. A-5.

payments. According to The Lewin Group, such a program would allow 19,700 low-income uninsured workers to enroll themselves and their families in their employer's plan.[25]

c) **Enforce waiting periods (minimum periods of being uninsured) for eligibility for the premium subsidy program, to discourage employers and employees from dropping employer coverage to enroll in public programs**. (Also create exceptions for involuntary loss of coverage, COBRA coverage, or qualifying events, such as marriage or birth.) Later in this document we discuss recommended expansions of public coverage. While these expansions are designed to assure coverage for the lowest-income Coloradans without access to employer-based coverage, there is a risk that eligible workers will drop their employer's coverage to take the new, cheaper public coverage. To discourage this "crowd-out" effect, the Commission recommends that each of its new public programs, including the subsidy program discussed above and the public program expansions discussed later, require that enrollees be uninsured for three to six months, depending on the program.

   This policy has the negative consequence of treating similarly situated individuals differently—an uninsured worker at a firm that offers coverage will be eligible for a subsidy while the insured worker will not. However, the Commission believes that this disparity is the necessary price for ensuring that public funds are not used to cover those who already have insurance. In fact, The Lewin Group analysis shows that the Commission's recommendations to require waiting lists, as well as those that to require those who are eligible for a subsidy and who have access to purchase employer coverage to buy it, results in public dollars covering the uninsured, instead of those who already have coverage, more so that the other four proposals reviewed by Lewin. (73.3% of program dollars cover the currently uninsured, compared to 36.5%-68.4% for the other four proposals.)

18) Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector."

Rationale

ADD

Recommendation

a) **Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector."** This entity would offer a choice of benefit packages with easily comparable price and quality information, certify health plans, and facilitate employer and employee contributions. Benefits of a Connector for individuals include information, education, and assistance with understanding health insurance options. Benefits of a Connector for small businesses include making it easier to offer health benefits to part-time and contract workers, portability of coverage if workers change jobs, encouraging competition between health plans, and facilitating employee choice of benefit plans. The Connector would build on the availability of 125 plans for employees, would require participating plans to use the same rating rules as in the individual and small group market,

[25] To further facilitate enrollment in employer coverage, the Commission recommends that qualifying for a subsidy be a qualifying event for enrollment in employer coverage. See Appendix X Recommendations to the Federal Government

and would offer three to four standard benefit plans with options for different levels of cost-sharing and provider networks. The Rural Task Force advised the Commission that a Connector would be an important mechanism for rural areas of the sate, where access to health insurance can be limited.

19) Maximize access to/enrollment in private coverage for working lower-income Coloradans who are not offered coverage at the workplace.

Rationale

Although Colorado currently has public programs that provide health insurance coverage to the poorest Coloradans, many families earn too much to qualify for these programs and are not offered employer coverage. For these individuals and families, purchasing a health insurance policy on their own can be financially burdensome. For example, families and individuals who earn between 200-300 percent of the poverty level (between $40,000 and $60,000 annual household income for a family of four) cannot afford a private family insurance policy that would cost $12,000 per year (check #) or 20-30 percent of their gross income.

Yet, private coverage may be more appropriate for these families than public programs. They may be able to contribute toward the cost of their coverage and may prefer health insurance policies similar to those offered by employers.

Almost one-half of the health care reform proposals received by the Commission recommended premium assistance to low-income families who do not qualify for public programs. Further, the Lewin Group estimates substantial subsidies (80% to 100% of premium cost) to this population would cover 143,000 uninsured Coloradans, or about 18 percent of Colorado's uninsured[26].

Recommendations

a) **Provide premium subsidies to workers who are not offered coverage at the workplace who earn less than 300% of poverty for purchase of private health insurance equivalent to CHP+ benefit package**. The Commission recommends that eligible families receive a sliding-scale subsidy between 80% and 100% of the premium cost. The Commission considered leaner subsidies. However, evaluation demonstrated that lower subsidies lead to lower enrollment rates, thus covering fewer of the currently uninsured. In addition, the Commission considered subsidizing a leaner benefit package, such as the Minimum Benefit Plan, instead of the CHP+ benefit package. Evaluation results indicated, however, that using the Minimum Benefit Plan would contribute to uncompensated care, as low-income families would not be able to pay for uncovered services. The Commission recommends use of the CHP+ package instead, a benefit package modeled, not on Medicaid, but on the Colorado Small Group Standard Plan.

b) **Provide premium subsidies to individuals and families who earn between 300-400% of poverty such that their premium cost of the Minimum Benefit Plan is no more than 9% of their income.** (The same subsidy would be available to workers with access to coverage at the workplace.)

[26] This estimate assumes that the other recommendations of the Commission, e.g. Medicaid and CHP+ expansions, are implemented.

c) **To facilitate enrollment and reduce fraud, use auto enrollment strategies that use existing state data to determine subsidy eligibility** (e.g. tax, wage, and nutrition program information).

20) Require all health insurance carriers operating in Colorado to offer a Minimum Benefit Plan in the individual market, with an emphasis on value-based and consumer-directed benefit design.

Rationale

Purchasing a health insurance policy can be a confusing and time-consuming task, particularly for individuals and families who purchase coverage without the assistance of an employer. In addition, uninsured Coloradans who are required to buy insurance under the individual mandate recommended by the Commission will need to understand what insurance to buy to comply with the new state law.

Recommendations

a) **Require all health insurance companies in Colorado to offer a Minimum Benefit Plan in the individual market**. The Minimum Benefit Plan, similar in concept to the existing Standard and Basic Plans in Colorado's small group market, could be varied by insurers to include a Health Savings Account (HSA) option or to reflect an insurer's provider network, such as an HMO or a PPO. A standardized plan will enable all purchasers of insured in Colorado to understand the minimum coverage they must buy to comply with the individual mandate, as well as to compare prices among various insurance companies.

b) **The Commission is not recommending exactly what the minimum plan should cover.** Instead, the Commission recommends that the "Improving Value in Health Care Commission" (discussed later in these recommendations) develop the basic benefit plan annually, emphasizing value-based and consumer-directed benefit design. However, we recommend that this benefit package include first-dollar coverage of preventive services, prescription drug coverage and parity between physical and mental health benefits.

21) Guarantee access to affordable coverage for Coloradans with health conditions (Implement in conjunction with Recommendation 16).

Rationale

Rising health insurance premiums are particularly difficult for Coloradans who do not have access to an employer health plan, because employers often contribute toward the premium cost and employee premiums (by statute for those employed by small businesses) are not based on the employee's health status. Individuals and families without employer coverage must bear the full cost of premiums and subsequent increases. In the worst cases, individuals and families cannot buy health insurance at all because of a pre-existing medical condition.

Recommendations

The following recommendations address changes to the individual health insurance market and CoverColorado, but assume that laws and regulations in the small group and large group markets would not change.

a) **Require health insurance companies to issue coverage (guarantee issue) to any individual or family who applies for individual health insurance and who is not eligible for the restructured CoverColorado program.** Almost 30% of the proposals received by the Commission recommended some form of guarantee issue in the individual market. The Commission recommends that insurance companies be required to sell health insurance policies to anyone who applies (and is not eligible for the expanded CoverColorado program, discussed in the following bullet), regardless of the applicant's past or current health conditions.. Such rules will assure access to affordable private coverage for sick individuals—individuals who would be required to have health insurance under an individual mandate.

b) **Allow health insurance companies to set premiums for these individuals and families based on their age and geographic location; disallow the consideration of past and current health conditions.** Over 30% of proposals received by the Commission recommended elimination of health status rating in the individual market**.** Further, insurance companies should be prohibited from charging sick individuals higher premiums and healthy people lower premiums. Instead, rates should be based solely on the applicant's age and geographic location. The negative consequence of this policy is that healthy individuals and families will actually experience higher rates under these new rules. While there is a risk that healthy enrollees will drop coverage if their premium rates increase, the Commission believes that the elimination of premiums based on health status is the fairest way to treat sick and healthy individuals who are required to buy insurance under an individual mandate.

c) **Restructure CoverColorado to cover those who apply for coverage, have an identifiable, high-cost health condition as defined by the newly expanded program and are not eligible for Medicaid, CHP+ or a premium subsidy,** and finance CoverColorado to ensure that premiums are equal to the standard rates in the individual market. The Commission recognizes that requiring insurance companies to cover sick individuals, whom they can currently deny, will raise costs to the insurance company and consequently premiums for all of their policyholders. To address this concern, the Commission recommends that the new insurance rules be accompanied by an expansion of CoverColorado, Colorado's existing insurance program for sick, high-cost individuals. Under its new mission and rules, CoverColorado would enroll all individuals who apply for individual coverage and who also have a health condition on a list of high-cost conditions. By expanding CoverColorado and enrolling those with high-cost, chronic conditions, the Commission believes that premiums for the remaining "healthy" individuals who purchase insurance will face affordable premiums. The Lewin Group estimates that, by expanding CoverColorado in this manner, 24,100 high-needs individuals would be enrolled in CoverColorado and that premium rates in the individual market will be reduced by X%. The CoverColorado program, in turn, would offer subsidized premium rates, equivalent to those offered to the "healthy" population. The Commission believes that the new CoverColorado program, coupled with the new insurance rules, will ensure affordable rates for both the "healthy" and "sick" individuals who, lacking access to employer coverage, must buy private coverage on their own.

22) Restructure and combine public programs (Medicaid and the Child Health Plan Plus) for parents, childless adults and children (excluding the aged, disabled and foster care eligibles).

Rationale

The Commission believes that Medicaid and CHP+ are the best vehicles for covering the lowest-income Coloradans. Yet, Colorado should not continue to enroll low-income families in poorly **performing** public programs that make it difficult for individuals and families to receive the care they need and for providers to be compensated adequately for their services. Before expanding public coverage, then (as discussed in Access and Choice Recommendation 9 below), we should reform it to reflect the best practices of private health insurance.

CHP+, with its emphasis on a commercial benefit package, managed care delivery system and adequate provider reimbursement rates, has been a success for enrollees and providers in terms of access and quality. The Commission, therefore, recommends using that program as the basis for fundamental Medicaid reforms.

Recommendations

a) **Merge Medicaid and CHP+ into one program for all parents, childless adults and children** (excluding the aged, disabled and foster care eligibles).

b) **Pay health plans at actuarially-sound rates and providers at least CHP+ rates in the new program**.

c) **For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75% of Medicare.** Increasing provider and plan reimbursements in this manner was included in almost 40 percent of the proposals received by the Commission. While the Commission recognizes that even this reimbursement level may not be optimal, we believe that this increase will attract more providers and improve access to care in the newly expanded program.

d) **Provide the CHP+ benefit and cost-sharing package to enrollees in the new program, including dental, with access to a Medicaid supplemental package, including EPSDT for children, for those who need Medicaid services.** AS DETERMINED HOW?

e) **Require enrollment in managed care, where available**.

23) Improve benefits and case management for the disabled and elderly in Medicaid.

Rationale

While healthy adults and children constitute the majority of Medicaid and CHP+ enrollees, the disabled and elderly account for approximately 68 percent of the costs in the Medicaid and CHP+ programs. In addition to the long-term care needs of these populations, disabled enrollees in Colorado Medicaid account for the largest share of physician and hospital spending, or 38 percent of these costs for Colorado Medicaid. Therefore, finding effective ways

to ensure access to ensure quality care for this population may have the greatest potential for improving their health status and reducing costs to the program.

Just was with the previous recommendation regarding combining Medicaid and CHP+, improvements for elderly and disabled Medicaid recipients should be implemented before expanding the Medicaid program.

Recommendations

In developing strategies to serve the needs of disabled and elderly Medicaid recipients, the Commission looked to the recommendations of its Vulnerable Populations Task Force (the Task Force's complete recommendations may be found in Appendix X). Where possible, the Commission recommends the following:

a) **Encourage enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care**.

b) **Promote care delivery in a consumer-directed, culturally competent manner to promote cost-efficiency and consumer satisfaction**.

c) **Provide care coordination and targeted case management services.** Targeted case management is a benefit that pays for social worker services so that medical providers can have access to supports that help their patients with housing, food, and other social problems.

d) **Provide dental coverage up to $1,000 per year.** Currently, Colorado's Medicaid program does not include adult dental benefits. Yet, oral health is part of physical health, and dental problems, when left untreated, can lead to serious and expensive complications.

e) **Explore potential for further reforms to Medicaid, particularly for those who are disabled** (see Appendix).

24) Improve delivery of services to vulnerable populations.

Rationale

In addition to improved Medicaid benefits, the Commission believes that additional efforts are needed to deliver meet the needs people with disabilities and other high-need populations. The recommendations that follow reflect strategies that are intended to ensure that vulnerable populations receive the medical care and services they need to remain healthy, to participate in the workforce, and to reside in non-institutional settings.

Recommendations

a) **Create a Medicaid buy-in program for working disabled individuals**. The Commission agrees with the Vulnerable Task Force recommendation to create a Medicaid buy-in program for working disabled individuals. The program would provide subsidized Medicaid buy-in for disabled individuals up to 450% of poverty, and a full-cost buy-in for those over 450% of poverty.

b) **Create a medically-correctable fund for those who can return to work or avoid institutionalization through a one-time expense**.

c) **Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services**.[27]

d) **Provide mental health parity in the Minimum Benefit Plan** (Recommendation 21).

e) **Establish a Medically-Needy or other catastrophic care program for those between 300% and 500% FPL to address the issue of people who have health insurance but do not have coverage for catastrophic events** (fund at $18 million in state funds).

25) Expand eligibility in the combined Medicaid/CHP+ program to cover more uninsured low-income Coloradans.

Rationale

The Commission believes that individuals and families who earn more than 200 percent FPL (or approximately $40,000 annual household income for a family of four) can afford to contribute something toward the cost of their health insurance and that they should enroll in private and employer health coverage, as described in the preceding recommendations. The Commission believes that families and individuals that earn less, however, do not earn an adequate amount to contribute toward the cost of premiums, out-of-pocket costs, or uncovered benefits.

A significant benefit to expanding public programs is that the federal government pays for at least one-half of all program expenses for eligible populations, making expansion of health coverage for this segment of Colorado's population significantly less expensive to the state. (Note, though, that federal financing is not always simple or guaranteed. See "A Note on Financing" at the conclusion of the Recommendations.)

Both Colorado health care stakeholders and the evaluation results suggest that expansion of public programs is an important component to guaranteeing health care coverage for all Coloradans. Over one-third of all health care reform proposals submitted to the Commission suggested expanding the Colorado Medicaid and CHP+ programs to serve more low-income individuals and families. Secondly, The Lewin Group estimates that expanding Medicaid and CHP+ to 205 percent FPL for all Coloradans would cover approximately 335,600 uninsured people, or 42 percent of the state's uninsured. [28]

Recommendations

a) **Expand Medicaid/CHP+ to cover all uninsured legal residents of Colorado under 205% of poverty.** The State of Colorado currently provides Medicaid or CHP+ coverage for children up

[27] Including the Children's HCBS waiver program, the Child Autism waiver program, the Adult Comprehensive waiver program, the Adult SLS waiver program, the Early Intervention waiver program, the CES waiver program and the Family support waiver program.

28 The Lewin Group. Colorado Model 5: Cost and Coverage Impacts. Presentation to the Commission. Revised November 28, 2007. Slide 7.

to this level of income; covering low-income adults through these programs would build on existing systems. These public programs serve low-income populations well by providing a comprehensive benefit package and requiring small copayments.

b) **Expand the Child Health Plan Program to children up to 250% of poverty**.

c) **Provide assistance with premiums and copayments to low-income, elderly Medicare enrollees.** The Lewin Group estimates that this will save the average Colorado senior household $622 per year.

d) **Restrict the expansion to adults with less than $100,000 in assets** excluding car, home, qualified retirement and educational accounts, and disability-related assets.

e) **Work with federal government to ensure federal funding for low-income childless adults;** do not fund expansion through reduction of services to current Medicaid and CHP+ eligibles. The Commission believes that the federal government should allow states more flexibility in how they structure their Medicaid and CHP+ programs, including federal financing for childless adults and waiting periods for higher income enrollees. (See Appendix A for the Commission's recommendations to the federal government.)

26) Ease barriers to enrollment in public programs.

Rationale

Current systems for getting coverage can be confusing and time-consuming, particularly for families who are eligible for public assistance. While the "Connector" presented in Recommendation 3 is designed to make enrollment in private coverage easier, other mechanisms are necessary to facilitate access to public coverage and the subsidy program.

Recommendations

a) **Use auto enrollment strategies to increase enrollment, reduce fraud, and lower administrative costs and pursue presumptive eligibility where possible.** Automatic enrollment means using existing state data (e.g. tax data, wage data, and nutrition program data) to identify and enroll families in coverage. These strategies reduce administrative burden on families and state agencies, and reduce chances for fraud. These strategies are particularly effective at covering children who are eligible for Medicaid and CHP+, but not enrolled. The Lewin Group estimates that auto enrollment strategies in Colorado would cover almost 50,000 uninsured children.

b) **Provide one-year continuous eligibility to childless adults, parents, and children in the newly merged Medicaid/CHP+ program.** In practice, this leads to shorter enrollment in the program; for example, the average length of enrollment for a child in Colorado Medicaid is 6 months. This "churn" creates administrative costs to the state and provider and interruptions in care for the family. Providing one year of eligibility promotes continuous care and reduces administrative costs for providers and the state.

c) **Change the eligibility rules for public programs that result in families enrolling in multiple programs to receive medical care.** Under current Colorado program rules, a family at 150 percent FPL (approximately $30,000 annual income for a family of four) with a 7-year-old child and a 3-year-old child would be required to enroll in three separate programs for medical care: parents in the Colorado Indigent Care Program, the 7-year-old in CHP+ and the 3-year-old in Medicaid. Not only does this require the family to apply for three programs – a difficult task for any of us – it also may require the family to enroll in three separate health plans and potentially to seek care from three separate physicians. To encourage this family to receive needed coverage and medical care, income and asset eligibility for public programs should be reformed so that families can always enroll in a single program for medical care coverage. The Commission's recommendations for reforming eligibility to achieve these and other goals are described in Recommendation X.

27) Enhance access to needed medical care, especially in rural Colorado where provider shortages are common.

Rationale

> Access to coverage doesn't equal access to care, especially in rural Colorado. Expanding insurance coverage in rural areas is moot unless there are sufficient providers, of all types, to serve them.
>
> --Rural Task Force for the Blue Ribbon Commission for Health Care Reform

The federal government has designated 34 percent of Colorado counties as Health Professional Shortage Areas, meaning that residents do not have ready access to an adequate number of providers.[29] As indicated in the excerpt above, insurance coverage alone is not sufficient in these areas to assure access to care.

In addition, in many rural communities, "safety net" providers such as federally qualified health centers and rural health centers are the only source of care. It is critical that any reforms implemented by the state enhance, not detract from, these providers' ability to serve their communities.

The Commission drew largely on the recommendations of its Rural Task Force in crafting recommendations to increase access to care in underserved areas of the state. (The entirety of the Rural Task Force's recommendations may be found in their final report, Appendix X). The Rural Task Force comprised 15 members from rural areas of Colorado, representing health care providers, businesses and consumers.

[29]Colorado Department of Public Health and Environment. Primary Care Health Professional Shortage Areas. July 2007. http://www.cdphe.state.co.us/pp/primarycare/shortage/pchpsa.pdf

Recommendations

The Commission recommends four major strategies for improving access to care in underserved areas of the state:

a) **Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients.** The Commission recommends that safety net providers, such as community health centers, continue to receive their existing funding to ensure that they can continue as the sole source of care in some underserved communities.

b) **Explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training.** Midlevel providers can substantively improve health care access and are an important part of the heath care resource mix in rural areas.

c) **Promote and build upon the existing statewide nurse advice line.** Such a mechanism can benefit rural populations and is likely to reduce the use of emergency departments for non-emergency healthcare services, reducing costs to small rural providers.

d) **Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas.** The Commission recognizes that technology infrastructure in rural areas is sometimes not sufficient to support telemedicine. Yet, in areas that can support this type of care, the Commission believes that use of telemedicine should be reimbursed.

e) **Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado**, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches.

28) Create an Consumer Advocacy Program

Rationale

As previously uninsured Coloradoans become eligible for public coverage and subsidies for private coverage, some may need assistance understanding how to access health care insurance programs and need health care services. Consumers may need assistance with understanding eligibility and application processes, how to choose and enroll in a health plan, how to access needed services, and how to appeal a benefit denial.

Recommendations

a) **Create a Consumer Advocacy Program that is independent and consumer-directed.** Functions of the Consumer Advocacy Program would include providing system navigators to guide people through the system, resolving problems, providing assistance with eligibility and benefit denials, and helping people qualify for Medicare and Social Security Income.

29) Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.

Rationale

Over one-quarter of the proposals submitted to the Commission proposed that Colorado create a single, public payer of all health care, similar to the system used in Canada. While the Commission evaluated one of these proposals (Proposal 4), the Commission decided against recommending this type of reform in Colorado because of its disruption of current private health insurance arrangements. The Commission was interested, however, in adopting one aspect of a single-payer plan: completely portable coverage that allows people to keep their health insurance coverage even through life changes such as switching jobs. Under a true single-payer system, residents of the state would be mandatorily enrolled in a state-run health program that would cover them regardless of their employment, income or health status. Thus, coverage continues regardless of life changes.

Recommendation

a) **Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.** Features of the plan that the Commission modeled included low co-payments and a commitment to enroll for a minimum number of years, possibly 10. (This minimum enrollment period would prevent people from enrolling only when they were sick.) Enrollees would pay for their enrollment through an additional state annual income tax of 8.1 percent. The state would have to pursue a major federal waiver to capture existing employer and Medicaid/CHP+ contributions for enrollees in the program. Although a voluntary program does not have the same benefits as a mandatory system (e.g. the elimination of most heath insurance companies and their related administrative costs), the program would give Colorado residents the option of enrolling in a health plan that will cover them as long as they remain residents of Colorado.

30) Continue to explore the feasibility of allowing employers to offer 24-hour coverage

Rationale

In 24-hour coverage, all of an employee's health needs- whether work-related or not-are covered by a single health insurer. Employers participating in 24-hour coverage pilot could experience savings in two areas: administrative costs and reduced litigation. Administrative costs may be reduced because employers only contract with one insurer for coverage of their workers instead of two insurers. Another possible area of savings is reduced litigation that stems from carriers disputing whether a given claim is work-related or not. Despite these possible savings, the Commission identified possible downsides to voluntary 24-hour coverage, such as only higher-risk employers opting for 24-hour coverage and what the resulting impact on disability claims, health claims, and premiums would be for all employers.

Recommendation

a) **Continue to explore the feasibility of allowing employers to offer 24-hour coverage**. Given the potential benefits and risks of a voluntary 24-hour coverage policy, the Commission recommends that Colorado continue to analyze the pros and cons of 24-hour coverage,

possibly further refining the concept to ensure that it would reduce premiums for participating employers and employees, without raising premiums for others.

PART 3: Adopt Recommendations as a Comprehensive Plan; Implement in Stages

31) Implement these recommendations of the Blue Ribbon Commission on Health Care Reform as a comprehensive, integrated package.

Rationale

This is a package of interconnected recommendations; together they are the Commission's vision for comprehensive health care reform in Colorado. The recommendations work together to increase affordability, increase access to health care, and ensure ongoing viability of Colorado's insurance markets. For example if Colorado were to implement an individual mandate (Recommendation 17), without providing subsidies for the purchase of private health insurance (Recommendations 18 and 20), many uninsured Coloradans would not comply with the mandate, as health insurance premiums would remain unaffordable for them. Another example is the Commission's recommendation to expand the Colorado Medicaid and CHP+ programs to all uninsured Coloradans under 200% of poverty (Recommendation 26). If this recommendation were to be implemented without reforming Medicaid provider reimbursement, as in Recommendation 23, thousands of uninsured Coloradans would become eligible for Medicaid, but likely would not be able to find a health care provider willing to treat them.

The following is a sampling of the interconnectedness of the Commission's recommendations:

Creation of an individual Mandate (Recommendation 17) depends on:

- Creation of a premium subsidy program (Recommendations 18 and 20)
- Creation of a Colorado Connector (Recommendation 19)
- Reforms in the individual insurance market (Recommendation 22)
- Expansion of Medicaid and CHP+ (Recommendation 26)

Reforms in the individual market (Recommendation 22) depend on:

- Creation of an individual mandate (Recommendation 17)
- Restructuring of CoverColorado (Recommendation 22c)

Expansion of Medicaid and CHP+ (Recommendation 26) depends on:

- Improvements to health plan and provider reimbursement (Recommendation 23)

Recommendations

a) **Adopt these recommendations of the Blue Ribbon Commission on Health Care Reform as a comprehensive, integrated package but do so in stages, increasing efficiency and assuring access before expanding coverage**. See the "Implementation Schedule" on the following pages.

Recommendations: Implementation Schedule

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Reduce Cost of Health Care and Improve Quality of Care				
Create the Colorado Health Care Value Authority (Recommendation 15)	Authority creates rules regarding administrative simplification (Recommendation 3), health care transparency (Recommendation 12) and the Consumer Advocacy Program (Recommendation 28). (Recommendation 15b)	Authority issues reports on prevention (Recommendation 4) medical homes (Recommendation 8), and end of-life care (Recommendation 6). (Recommendation 15c)	Authority issues reports on evidence-based medicine (Recommendation 10) and provider reimbursement (Recommendation 11). (Recommendation 15c)	Authority issues evaluation of health care reform (Recommendation 15c)
Reduce Costs of Employer and Individual Private Coverage				
Create Colorado Connector				
	Create Colorado Connector (Recommendation 18)		Offer enrollment in the Colorado Connector to small businesses and individuals (Recommendation 18)	
Require employers to offer 125 premium-only plans (Colorado Department of Labor)				
	Issue rules regarding state 125 plans (Recommendation 17a)	Require Colorado employers to set up Section 125 premium-only plans (Recommendation 17a)		
Reduce health insurance premiums for low-income uninsured workers and their families (Colorado Connector)				
		Issue rules regarding the premium subsidy program (Recommendation 19)	Implement premium subsidy program for low-income uninsured workers (Recommendations 17b and 19)	
Expand and Reform Colorado Medicaid and Child Health Plan				

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Reform Colorado Medicaid for adults and children (Department of Health Care Policy and Financing)				
Partner with federal government to secure approval and funding for Colorado Medicaid reform and expansion (Recommendation 22)	Secure approval from federal government for Colorado Medicaid reform and expansion (Recommendation 22)	Combine and restructure the Colorado Medicaid and Child Health Plan programs for adults and children (Recommendation 22)		
Increase physician and health plan participation in Medicaid (Department of Health Care Policy and Financing)				
Implement one-year continuous eligibility for Colorado Medicaid (Recommendation 26)	Increase Medicaid physician reimbursement to at least 75% of Medicare (Recommendation 22c)	Pay physicians and health plans in combined Medicaid/CHP+ program using CHP+ methodology (Recommendation 22b) Require enrollment in managed care for the combined Medicaid/CHP+ program (Recommendation 22e)		
Improve Medicaid benefits (Department of Health Care Policy and Financing)				
		Cover care coordination, targeted case management, and dental care (Recommendation 23)		
Expand Colorado Medicaid and Child Health Plan for parents, children, and childless adults (Department of Health Care Policy and Financing)				
Implement auto enrollment and one-year continuous eligibility for Colorado Medicaid (Recommendation 26)	Expand child eligibility to 250% of poverty and parent eligibility to 205% of poverty(Recommendation 25)	Create Medicaid coverage for childless adults up to 205% of poverty (Recommendation 25)		

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Expand Colorado Medicaid and Child Health Plan for disabled and other vulnerable populations (Department of Health Care Policy and Financing)				
Create Medicaid Buy-In program for working disabled individuals (Recommendation 24)	Create Medically-Correctable Program (Recommendation 24)	Increase number of people served by home-and-community-based waivers (Recommendation 24)		Create Medically Needy or Catastrophic Care Fund (Recommendation 24)
Improve Access to Individual Private Coverage				
Require health insurance companies to offer the Minimum Benefit Plan in the individual market (Colorado Health Care Value Authority)				
			Authority issues rules on the Minimum Benefit Plan (Recommendation 16)	
Restructure CoverColorado (CoverColorado)				
		Issue rules regarding restructured CoverColorado program (Recommendation 21)	Implement rules regarding restructured CoverColorado program (Recommendation 21)	
Reform the Colorado individual insurance market (Colorado Division of Insurance)				
		Issue rules regarding guarantee issue and modified community rating the individual market (Recommendation 21 and 21)	Implement guarantee issue and modified community rating in the individual insurance market for those who are not eligible for the restructured CoverColorado program (Recommendation 21 and 21)	
Require Every Legal Resident of Colorado to Have Health Insurance at Least Equal to the Minimum Benefit Package				
		Issue rules regarding the individual mandate, including the affordability exception and tax penalty (Recommendation 16	Implement individual mandate, with affordability exception and tax penalty (Recommendation 16	

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Assure Access to Care, Especially in Rural Areas				
Create safety net provider transition plan to assure adequate funding during health care reform for these providers.	Explore ways to minimize barriers to physician and dentist extenders from practicing to the fullest extent of their licensure and training (Recommendation 7	Develop and expand mechanism to recruit and retain health care workers who will provide services in underserved areas of Colorado (Recommendation 27)		
Continue to Explore Options for Improving Access to Health Insurance for Coloradans				
Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled (Recommendation 29	Continue to explore the feasibility of allowing employers to offer 24-hour coverage (Recommendation 30			

PART 4: Dissolve the Commission on January 31, 2008

32) Dissolve the Commission once its final report is made to the General Assembly Jan. 31, 2008

Rationale

ADD

Recommendation

a) **Dissolve the Commission once its final report is made to the General Assembly January 31, 2008**.

Financing

The Commission recognizes that its charge did not include identifying funding sources for its reforms, and that such decisions are the purview of the General Assembly. We note, however, a few important considerations for legislators:

By building upon the existing system of employer-sponsored insurance, these reforms retain a crucial funding mechanism: employer contributions.

The public program expansions suggested here will allow Colorado to maximize federal dollars coming into the state but will, in some cases, require waivers from the federal government. The Lewin Group has identified $842 million in annual federal funding that would be depending on Colorado's ability to secure a federal waiver to fund Medicaid and CHP+ expansions and premium subsidies. [30]

[30] The Lewin Group. Colorado Model 5: Cost and Coverage Impacts. Slide 13. Presentation to the Commission. November 15, 2007. Revised November 28, 2007.

Recommendations to the Federal Government

Issues for Further Study

Minority Reports

Appendices

Appendix 1: Senate Bill 208

Appendix 2: Specifications of Evaluated Health Care Reform Proposals

Appendix 3: Final Report of The Lewin Group

Appendix 4: Public Input

Appendix 5: Task Force Reports

Appendix 6: Summary of Commission Recommendations

PART 1

Reducing Health Care Costs, while Enhancing Quality of Care

1) Slow the rate of growth of employer and private health insurance premiums by covering the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing the cost shift.

    a) Reduce uncompensated care by covering at least 85% of the uninsured in Colorado, through the recommendations in Part 3.

    b) Reduce cost-shifting by increasing Medicaid provider reimbursements (See Recommendation 23).

2) Reduce employee premiums for health insurance.

    a) Require Colorado employers to establish at least a Section 125 premium-only plan that allows employees to purchase health insurance with pre-tax dollars (See Recommendation 18a).

    b) Provide subsidies for uninsured low-income workers below 300% FPL to purchase their employer's plan. (See Recommendation 18b).

3) Reduce administrative costs.

    a) Require health insurers and encourage all payers in Colorado to use standard claims attachment requirements, eligibility and coverage verification systems, standard electronic ID cards, standard prior authorization procedures and uniform insurance application forms.

    b) Combine administrative functions of public health insurance programs (such as Medicaid, CHP+, premium subsidy program, CoverColorado).

    c) Review regulatory requirements on third-party payers and providers with the goal of reducing administrative burden.

4) Increase use of prevention and chronic care management.

    a) Where allowed by HIPAA, allow health insurance premiums to be reduced for enrollees who engage in healthy behaviors.

    b) Eliminate patient copayments for preventive care and reduce patient copayments for chronic care management services as defined by nationally-recognized, Colorado-vetted uniform guidelines, such as those developed by the Colorado Clinical Guidelines Collaborative.

    c) Encourage employers to provide workplace wellness programs.

    d) Encourage individual responsibility for health, wellness and preventive behavior.

e) Increase funding for local public health agencies in Colorado to perform functions such as preventing disease and injury, assessing community health, and promoting healthy behavior.

5) Conduct a comprehensive review of current Colorado long-term care information as a supplement to any review of the Commission reports, such as the SB 173 report , the report of the Developmental Disability Interim Committee, the Medicaid Redesign Project (SB 06-128), and the National Clearinghouse for Long-Term Care Information.

6) Improve end-of-life care.

   a) Identify a process to develop consensus, by a multi-stakeholder group, based upon best scientific evidence regarding strategies to foster clinically, ethically, and culturally appropriate end-of-life care, including palliative and hospice care.

   b) Ask patients, upon entry to a nursing home, home health, or other critical point of access, to complete an advanced directive. There would be no requirement to complete an advanced directive, patients would be fully-informed, there would be no outside pressure to complete the form, and revocation rights would be clear and simple.

7) Commission an independent study to explore ways to minimize barriers to physician extenders such as Advanced Practice Nurses from practicing to the fullest extent of their licensure and training.

8) Provide a medical home for all Coloradans.

   a) Enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs."

   b) Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and CoverColorado programs.

9) Support the adoption of health information technology.

   a) Support the creation of a statewide health information network, focusing on interoperability.

   b) Support the creation of an electronic health record for every Coloradoan, with protections for patient privacy.

10) Support the provision of evidence-based medicine[31].

31 Evidence-based medicine is defined as "A set of principles and methods intended to ensure that, to the greatest extent possible, population-based policies and individual medical decisions are consistent with the evidence of effectiveness and benefit."

a) Adopt population-specific care guidelines and performance measures, where they exist, based on existing national, evidence-based guidelines and measures, recognizing the importance of patient safety and best care for each patient.

b) Develop a statewide system aggregating data from all payer plans, public and private, building upon regional systems or efforts already taking place for sharing data among providers

11) Pay providers based on quality.

a) Pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care, and use of health information technology.

12) Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g. Web site).

a) Require DOI to report annually to the legislature regarding financial information on licensed carriers and public coverage programs; information should include medical loss ratios, administrative costs, etc, by line of business; require Medicaid, CHP+, CoverColorado and other public coverage programs to provide DOI with this information; and require brokers to report their compensation to their clients.

13) Promote consumer choice and direction in the health care system.

a) Provide a choice of Minimum Benefit Plans, including a Health Savings Account option, for all consumers purchasing in the individual insurance market (Recommendation 22).

b) Create a Connector for individuals and employees (Recommendation 19).

c) Increase price and quality transparency (Recommendation 13).

d) Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care.

14) Examine and expand the efforts of Colorado communities which have been proven over the years to enhance quality and lower cost.

15) Create a multi-stakeholder "Improving Value in Health Care Authority" to:

a) Create this multi-stakeholder group to fundamentally realign incentives to in the Colorado health care system to reduce costs and improve outcomes.

b) Give the Authority rule-making authority to implement the Commission's recommendations regarding administrative simplification (Recommendation 4), health care transparency (Recommendation 13), design of the Minimum Benefit Package (Recommendation 17b) and the Ombudsman and Advocacy Program (Recommendation 29).

c) Direct the Authority to develop a statewide system aggregating data from all payer plans, public and private, building upon regional systems or efforts already taking place for sharing data among providers (Recommendation 11b)

d) Direct the Authority to study and make recommendations to the Governor, state legislature, and rule-making agencies regarding prevention (Recommendation 6), medical homes (Recommendation 7), end-of-life care (Recommendation 8), health information technology (Recommendation 10), evidence-based medicine (Recommendation 11), provider reimbursement (Recommendation 12).

e) The Authority will also be responsible for assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers.

f) Establish the Authority before embarking on the improvements to coverage and access described in Part 3.

PART 2

Improving Access to Care, with Mechanisms to Provide Choices

16) Require every legal resident of Colorado to have at least a Minimum Benefit Plan, with provisions to make the mandate enforceable.

a) Require purchase of a Minimum Benefit plan (average monthly premium of approximately $200 for an individual).

b) Design and periodically review the Minimum Benefit Plan through the "Improving Value Authority." Ensure that the process to create the minimum benefit package is transparent, participatory, equitable, compassionate, sensitive to value, flexible and responsive.

c) Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level. Assuring affordability should include consideration of both premium and out-of-pocket costs.

d) Enforce through tax penalty; automatically enroll those who are eligible into fully-subsidized public coverage programs.

17) Implement measures to encourage employees to participate in employer-sponsored coverage.

a) Require Colorado employers to establish premium-only Section 125 plans that allow employees to purchase health insurance with pre-tax dollars.

b) Provide subsidies for uninsured low-income workers below 400% FPL to purchase their employer's plan.

c) Enforce waiting periods (minimum periods of being uninsured) for eligibility for the premium subsidy program, to discourage employers and employees from dropping employer coverage

to enroll in public programs; create exceptions for involuntary loss of coverage, COBRA coverage, or qualifying events, such as marriage or birth.

18) Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector."

    a) Offer three to four standard benefit plans.

    b) Certify participating health plans.

    c) Provide information and education, such as comparative price and quality information.

    d) Use same rating rules as the reformed individual and current small group market.

    e) Serve Colorado populations statewide

19) Maximize access to/enrollment in private coverage for working lower-income Coloradans who are not offered coverage at the workplace.

    a) Provide premium subsidies to workers who are not offered coverage at the workplace who earn less than 300% of poverty for purchase of private health insurance equivalent to CHP+ benefit package.

    b) Provide premium subsidies to individuals and families who earn between 300-400% of poverty such that their premium cost of the Minimum Benefit Plan is no more than 9% of their income. (The same subsidy would be available to workers with access to coverage at the workplace.)

    c) To facilitate enrollment and reduce fraud, use auto enrollment strategies that use existing state data to determine subsidy eligibility (e.g. tax, wage, and nutrition program information).

20) Require all health insurance carriers operating in Colorado to offer a Minimum Benefit Plan in the individual market, with an emphasis on value-based and consumer-directed benefit design.

    a) Require all health carriers offering health insurance in Colorado to offer a Minimum Benefit Plan in the individual market.

21) Guarantee access to affordable coverage for Coloradans with health conditions (Implement in conjunction with Recommendation 17).

    a) Require health insurance companies to issue coverage (guarantee issue) to any individual or family who applies for individual health insurance and who is not eligible for the restructured CoverColorado program.

    b) Allow health insurance companies to set premiums for these individuals and families based on their age and geographic location; disallow the consideration of past and current health conditions.

c) Restructure CoverColorado to cover those who apply for coverage, have an identifiable, high-cost health condition as defined by the newly expanded program and are not eligible for Medicaid, CHP+ or a premium subsidy. Finance CoverColorado to ensure that premiums are equal to the standard rates in the individual market.

22) Restructure and combine public programs (Medicaid and the Child Health Plan Plus) for parents, childless adults and children (excluding the aged, disabled and foster care eligibles).

a) Merge Medicaid and CHP+ into one program for all parents, childless adults and children (excluding the aged, disabled and foster care eligibles).

b) Pay health plans at actuarially-sound rates and providers at least CHP+ rates in the new program.

c) For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75% of Medicare.

d) Provide the CHP+ benefit and cost-sharing package to enrollees in the new program, including dental, with access to a Medicaid supplemental package, including EPSDT for children, for those who need Medicaid services.

e) Require enrollment in managed care, where available.

23) Improve benefits and case management for the disabled and elderly in Medicaid.

a) Encourage enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care.

b) Promote care delivery in a consumer-directed, culturally competent manner to promote cost-efficiency and consumer satisfaction.

c) Provide care coordination and targeted case management services.

d) Provide dental coverage up to $1,000 per year.

e) Explore potential for further reforms to Medicaid, particularly for those who are disabled (see Appendix).

24) Improve delivery of services to vulnerable populations.

a) Create a Medicaid buy-in program for working disabled individuals.

b) Create a medically-correctable fund for those who can return to work or avoid institutionalization through a one-time expense.

c) Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services.32

d) Provide mental health parity in the Minimum Benefit Plan (Recommendation 21).

e) Establish a Medically-Needy or other catastrophic care program for those between 300% and 500% FPL to address the issue of people who have health insurance but do not have coverage for catastrophic events (fund at $18 million in state funds).

25) Expand eligibility in the combined Medicaid/CHP+ program to cover more uninsured low-income Coloradans.

a) Expand Medicaid/CHP+ to cover all uninsured legal residents of Colorado under 205% of poverty.

b) Expand CHP+ for children up to 250% of poverty

c) Provide assistance with premiums and copayments to low-income, elderly Medicare enrollees up to 205% of poverty.

d) Restrict the expansion to adults with less than $100,000 in assets excluding car, home, qualified retirement and educational accounts, and disability-related assets.

e) Work with federal government to ensure federal funding for low-income childless adults; do not fund expansion through reduction of services to current Medicaid and CHP+ eligibles

26) Ease barriers to enrollment in public programs.

a) Use auto enrollment strategies to increase enrollment, reduce fraud, and lower administrative costs and pursue presumptive eligibility where possible.

b) Provide one-year continuous eligibility to childless adults, parents, and children in the newly merged Medicaid/CHP+ program.

27) Enhance access to needed medical care, especially in rural Colorado where provider shortages are common.

a) Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients.

b) Explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training.

c) Promote and build upon the existing statewide nurse advice line.

[32] Including the Children's HCBS waiver program, the Child Autism waiver program, the Adult Comprehensive waiver program, the Adult SLS waiver program, the Early Intervention waiver program, the CES waiver program and the Family support waiver program.

d) Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas.

e) Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches.

28) Create an Consumer Advocacy Program

a) Create a program that is independent and consumer-directed.

b) Provide system navigators to guide people through the system.

c) Resolve problems.

d) Provide assistance with eligibility and benefit denials.

e) Help qualify people on Medicaid for Medicare.

f) Help people qualify for SSI.

29) Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.

30) Continue to explore the feasibility of allowing employers to offer 24-hour coverage

PART 3

Increase efficiency and access before expanding coverage

PART 4

Dissolve the Commission once its final report is made to the General Assembly January.31, 2008

Appendix 7: Medicaid Reform Ideas for Further Study

Medicaid Reform Ideas Recommended for Further Study

1) Guarantee prompt (direct) reimbursement to clients and providers for any eligible expenses incurred during any delays in eligibility or periods in which the individual met all other periods that the client met all eligibility requirements, but for submission of an application (with a reasonable time limit), or if the client was required to self-pay, regardless of whether the service/supply was provided by a authorized Medicaid provider (e.g. hiring a neighbor for home care v. an agency).

2) Require all Medicaid recipients to have needed care coordination that includes prescription coordination and management, including medication review of new and continuing prescriptions.

3) Provide consumer training and education to allow consumers to identify savings in their own care and potentially provide incentives for doing so.

4) Pursue strategies for providing more reliable transportation, including funding strategies for Medicaid recipients that address inter-agency conflicts.

5) Combine waiver programs where appropriate (e.g. waivers with similar benefits thus saving on admin costs).

6) Support strategies to increase access to home based care in a cost effective way, so that people currently hospitalized (example vent dependent kids) can go home- and receive adequate care in the community. Results in long term savings.

7) Investigate stipend respite care as a benefit for eligible waiver participants. (Saves money because people can go home from hospital).

8) Look at pooling DME purchasing.
Can we purchase DME more cheaply or use equipment more efficiently? Set aside funding to help with this- example of potential savings is permitting recycling of wheelchairs, etc.

9) Create consumer-directed program for supplies. For example, Medicaid enrollees can buy Depends much more cheaply over the counter in the market place than through a Medicaid supply company.

10) Create new program for care coordinator to facilitate getting people transitioning out of corrections or the foster care system on to SSI and Medicaid as appropriate.

11) Study how to provide health management and care coordination for foster care children.

12) Facilitate transition to services for those on Medicaid aged 18-21, particularly across multiple systems.

13) Assist veterans transitioning from VA medical Services to DDS and SSI

14) Simplify and standardize entry into all HCBS programs.

15) Integrate systems so that mental health, education, and human services all work together to get appropriate services to children particularly when a child needs institutional care. Long term savings in getting appropriate care to kids when they need it.

16) Integrate mental health reform with health care reform. Look at the other recommendations for mental health coming from interim committees and DCCO.

17) Generally eliminate prior authorization requirement for over-the-counter products costing less than $100, with appropriate utilization review.

Appendix 8: How Task Force Recommendations were Incorporated into Commission Recommendations

Task Force Recommendation	How the Commission incorporated the recommendation
Business Task Force Recommendations	
Do not require employers to offer insurance or pay an assessment	Commission does not recommend an employer mandate or assessment
Exempt businesses under 10 employees from providing Section 125 plans	Commission modified recommendation to require all Colorado employers to offer Section 125 *premium-only* plans, which are less burdensome to establish (Recommendation 18a)
Require Coloradans to have health insurance	Commission recommends that all Coloradans be required to have health insurance (Recommendation 17a)
Expand public programs to reduce cost-shifting, with considerations for the effect on state taxes and provider reimbursement	Commission recommends expansion of public programs to reduce the number of uninsured and reduce cost-shifting. The Commission further recommends increases to Medicaid physician reimbursement. The Commission does not identify a financing mechanism for expansion of public programs. (Recommendations 23 and 26)
Structure premium subsidies to reduce administrative burden on employers	Commission recommends that premium subsidy checks be sent directly to employees, not employers, so that administrative burden on employers will be reduced. (Discussed in Recommendation 18)
Provider Task Force Recommendations	
Enable the provision, coordination and integration of patient-centered care, including "healthy hand-offs."	The Commission adopted this recommendation in its recommendation regarding medical homes. (Recommendation 7a)
Encourage the development of a statewide system aggregating data from all payer plans, public and private	The Commission adopted this recommendation as part of its recommendations regarding the promotion of evidence-based medicine (Recommendation 12b)
Standardize benefit packages, claim forms, payment processes, etc across health plans to improve transparency and minimize administrative costs.	The Commission recommends the standardization of claims attachment requirements, eligibility and coverage verification systems, standard electronic ID cards, standard prior authorization procedures and uniform insurance application forms. (Recommendation 4a)

Task Force Recommendation	How the Commission incorporated the recommendation
Integrate public and private physical health systems to incent consumer adherence and enable care to be provided by the most appropriate health care provider.	The Commission does not directly address the issue of public and private physical health system integration.
Get serious about changing reimbursements and incentives across all payers—public and private	The Commission recommends that providers be paid based on the quality of care they provide and that price and quality information be made readily available to consumers. (Recommendations 13 and 14)
Develop and expand state-based loan repayment/forgiveness systems/tax credits and other mechanisms to recruit and retain health care workers who will serve the underserved and provide a primary care based health care home for all.	The Commission adopted this recommendation in its recommendations addressing access to care (Recommendation 18e)
Rural Task Force Recommendations	
Use the Rural Urban Commuter Area definition of "rural"	The Commission does not recommend a definition for rural, but suggest strategies aimed to improve access to care in areas of the state where there have traditionally been a shortage of health care providers (Recommendation 28)
Test reform proposals to assure that safety net providers are not negatively affected	The Commission recommends that current cost-based Medicaid payments to safety net providers continue (Recommendation 28a) and that a Safety Net Transition Plan be developed in the early stages of health care reform in Colorado to ensure adequate funding to these providers (Recommendation 32 and Implementation Schedule)
Expand the scope of practice for non-physician health care professionals.	The Commission recommends that Colorado explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training (Recommendation 28b)
Increase funding to health care provider loan repayment providers who serve in Health Professional Shortage Areas.	The Commission recommends that Colorado develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches. (Recommendation 28e)

Task Force Recommendation	How the Commission incorporated the recommendation
Increase funding and marketing for medical education of providers who are on a rural track program in a primary care specialty.	The Commission did not directly recommend this strategy, but this recommendation could be studied as part of the Commission's recommendation to further study a variety of strategies to increase the number of health care workers who will provide services in underserved areas of Colorado (see previous recommendation).
Assure basic plan coverage to include oral health, behavioral health and vision care services.	The Commission recommends that the Minimum Benefit Plan provide mental health parity coverage (Recommendation 25d). The Commission did not further specify the benefits to be included in the plan, but rather recommends that a multi-stakeholder group design and periodically review the Minimum Benefit Plan to balance coverage and affordability. (17b)
Modify state regulations that prevent or set unacceptably high standards for the co-location and mixed use of some healthcare facilities.	The Commission did not directly address this issue in its recommendations.
Increase Medicaid reimbursement to parity with Medicare reimbursement in designated Health Professional Shortage Areas.	The Commission is recommending that Medicaid physicians be reimbursed at least 75% of Medicare rates, with a recommendation that it eventually be raised to 100%. In addition, the Commission is recommending that all Medicaid providers serving children and parents be reimbursed at CHP+ rates (e.g. for physicians, approximately 80% of Medicare[33]). (Recommendations 23b and 23c)
Assure adequate technical infrastructure and staff for telemedicine programs in rural areas to deliver chronic disease management and specialty consultation.	While the Commission does not make recommendations regarding technical infrastructure and staff, the Commission recommends that Colorado Medicaid and CHP+ expand their telemedicine benefits (Recommendation 28d)
The use of a 24-hour telephone triage nurse line for patients will benefit rural populations.	The Commission recommends that Colorado promote and build upon the existing statewide nurse advice line. (Recommendation 28c)

[33] This rate is used in the CHP+ managed fee-for-service network.

Task Force Recommendation	How the Commission incorporated the recommendation
Increase support for community-based organizations and local governments to assist families through eligibility and enrollment processes.	While the Commission does not directly make recommendations regarding local support for eligibility processes, the Commission recommends that eligibility and enrollment be simplified through the use of auto enrollment in public programs (use of existing tax, wage, and nutrition data) to reduce application burden on families. (Recommendation 27)
Enrollment in any state mandated health plan must occur automatically at the point of service, if the patient has not previously enrolled in an insurance plan.	The Commission does not directly address the issue of where application and enrollment would happen in Colorado communities, but believes that auto enrollment and one-year continuous eligibility should make application and enrollment into public programs faster, more accurate, and less burdensome for families and providers. (Recommendation 27)
The use of an insurance connector is likely to benefit rural populations; however, access to a connector should not be limited to the web.	The Commission recommends that the Colorado Connector be accessible to individuals and families in Colorado statewide (Recommendation 19)
Any governing body, which emerges from reform efforts, must include at least proportional representation from rural areas of Colorado.	The Commission does not address the issues of governance in its recommendations.
Test any geographic community rating proposals, which isolate rural populations from urban populations, to assure that they do not disadvantage rural populations.	The Commission recommends that the individual market in Colorado adopt modified community rating, which eliminates health status rating, but allows age and geographic rating. (Recommendation 22b) The Commission believes that geographic rating will benefit most rural areas, as urban areas tend to have higher health care costs than rural areas.
Test all proposed financing mechanisms to determine if they will disparately affect rural populations.	The Commission does not address financing in its recommendations.
Test economic incentives to providers and insurance plans to assure that modeling considers the limited health care provider capacity in most rural areas of Colorado.	The Commission recommendations attempt to increase access to providers in rural areas through a variety of mechanisms (Recommendation 28). The Commission also hopes that a reformed individual market, expanded CoverColorado, and new Colorado Connector will expand access to health insurance in rural areas. (Recommendations 19 and 22)
Establish rules to protect rural providers from unreasonable financial risk.	The Commission recommendations do not dictate the use of managed care in rural areas.

Task Force Recommendation	How the Commission incorporated the recommendation
Healthcare reform must place a greater emphasis on wellness and prevention by increasing funding for the public health system.	The Commission recommends increasing funding for local public health agencies in Colorado to perform functions such as preventing disease and injury, assessing community health, and promoting healthy behavior. (Recommendation 6e)
Vulnerable Populations Task Force Recommendations	
The safety net must be preserved and strengthened.	The Commission recommends that current cost-based Medicaid payments to safety net providers continue (Recommendation 28a) and that a Safety Net Transition Plan be developed in the early stages of health care reform in Colorado to ensure adequate funding to these providers (Recommendation 32 and Implementation Schedule)
Long term care needs to be evaluated and planned for in detail, both current and projected future needs.	The Commission believes that it did not have enough time to adequately address long-term care in Colorado. Instead, the Commission recommends that Colorado conduct a comprehensive review of current Colorado long-term care information as a supplement to the Commission's recommendations (Recommendation 8)
Any new proposal should include existing mandates provided by state law.	The Commission does not recommend elimination of any mandate provided by state law.
Build on successful local initiatives that are working for vulnerable populations.	The Commission recommends that Colorado examine and expand the efforts of Colorado communities which have been proven over the years to enhance quality and lower cost. (Recommendation 15)
Ensure that insurance plans provide comprehensive, high quality healthcare.	The Commission recommends that every Colorado under 200% of poverty be eligible for a Medicaid-equivalent benefit package (Recommendation 26). The Commission further recommends that uninsured workers between 200% and 300% of poverty be given a subsidy for a CHP+ benefit package (Recommendation 20a). Finally, the Commission did not recommend the benefits that would be included in the Minimum Benefit package, but suggests that a multi-stakeholder group design and periodically review this benefit package (Recommendation 17b)

Task Force Recommendation	How the Commission incorporated the recommendation
Focus on wellness and prevention. Incentivize consumers to engage in healthy behaviors and use appropriate preventive care. Eliminate co-payments for evidence based preventive care such as mammography screening.	These recommendations are similar to the Commission's recommendations regarding prevention (Recommendation 6)
Decrease complexity of health care plans and provide consumer education in acceptable mediums. Provide tools that enable consumers to make informed choices. Health care plans should be easy to navigate.	The Commission recommends that the state create a Colorado Connector to make health insurance easier to buy (Recommendation 19), that the state make information on insurer and provider price and quality more available (Recommendation 14), and that the state create a Consumer Advocacy Program to assist people with accessing the insurance and medical care they need (Recommendation 29).
Provide consumer/family friendly appeals processes with advance notice and ombudsmen.	The Commission did not directly address the issue of appeals processes.
Consumer satisfaction data should be collected and reported by an entity without conflict of interest.	The Commission recommends that Colorado ensure that information on insurer and provider price and quality is available to all Coloradans, with consumer satisfaction data being an important component of quality information (Recommendation 14)
Provide transparency and accountability.	The Commission recommends that Colorado increase transparency by providing more information to consumers on the cost and quality of health insurance and health care in Colorado (Recommendation 14). The Commission did not directly address the issue of governance of programs in its recommendations.
Contain administrative costs while providing high quality comprehensive care, i.e. National Association of Community Health Centers.	The Commission's recommendations do not require consumers or the State of Colorado to use a particular kind of health care provider. The Commission does recommend that Colorado ensure the viability of safety net providers (Recommendation 28a).
Expand Health Information Technology to allow quality seamless care, reduce medical error and forgo the need to duplicate care.	The Commission recommends the creation and expansion of the use of health information technology to increase quality and reduce health care costs in Colorado (Recommendation 11).
Recognize the value of culturally appropriate and holistic medicine including non-allopathic medicine and traditional healers/non-traditional western providers.	The Commission did not directly address holistic and alternative medicine in its recommendations.

Task Force Recommendation	How the Commission incorporated the recommendation
Provide continuous coverage with portability that allows interstate travel and reciprocity with other states.	The Commission recommendations attempt to increase portability of health insurance coverage for Coloradans through two mechanisms: the Colorado Connector (Recommendation 19) and further study of a program like the Optional Continuous Coverage Program modeled by the Commission (Recommendation 30).
Promote research into best medical practices for vulnerable populations.	The Commission's recommendations do not directly address medical research. The Commission does recommend, however, that the new Value Authority develop of a statewide system aggregating data from all payer plans, public and private, which it believes is the measuring the efficacy and efficiency of care for different populations.
Expand Medicaid to Federal Levels. Endorse Medicaid Buy-In and Ticket to Work.	The Commission recommends that Medicaid and CHP+ be expanded to cover every individual and family in Colorado under 200% of the poverty level (Recommendation 26). The Commission also recommends that the state create a buy-in program, that includes Ticket to Work eligibility, for working disabled individuals (25a)
Decrease the complexity of Medicaid via: a simplified application process, 12 months continuous eligibility, presumptive eligibility, passive reenrollment, and elimination of unnecessary verifications; expansion of the state definition of developmental disability to match the federal definition and consolidate the 14 Medicaid Waiver programs accordingly	The Commission recommends 12 month continuous eligibility for Medicaid (Recommendation 27b) and presumptive eligibility where possible (Recommendation 27a). Expansion of Medicaid to childless adults up to 200% of poverty will also allow disabled adults under 200% of poverty to become income-eligible for Medicaid, without a wait for SSI eligibility determination. The Commission also recommends further study of the combining of waiver programs (Appendix X #5)

Task Force Recommendation	How the Commission incorporated the recommendation
Increase reimbursement for Medicaid providers, with incentives for those who provide quality care to high needs populations.	The Commission recommends that Medicaid physicians be reimbursed at least 75% of Medicare rates, with a recommendation that it eventually be raised to 100%. In addition, the Commission is recommending that all Medicaid providers serving children and parents be reimbursed at CHP+ rates (e.g. for physicians, approximately 80% of Medicare[34]). (Recommendations 23b and 23c). The Commission also recommends that all provider in Colorado be paid based on the quality of their outcomes (Recommendation 13).
Build on the success of the Consumer directed Attendant Support Program by expediting implementation of HB 05-1243.	The Commission recommends increasing consumer direction in health care (Recommendation 5); however, the Commission believes that it did not have enough time to adequately address long-term care in Colorado. Instead, the Commission recommends that Colorado conduct a comprehensive review of current Colorado long-term care information as a supplement to the Commission's recommendations (Recommendation 8)
Enable consumer directed care for Medicaid DME purchase to maximize cost savings	The Commission recommends increasing consumer direction in health care (Recommendation 5), but did not directly address the issue of DME purchase in Medicaid.
Allow Medicaid services to be provided in the family home	The Commission recommends expansion of the Medicaid Home-and-Community-Based Waiver programs (Recommendation 25c). The Commission also recommends further study of home-based care (Appendix X, #6)
Encourage Medicaid fraud detection via consumer education and incentives	The Commission recommends further study of consumer training programs to allow consumers to identify savings in their own care (Appendix X, #3)
Expand Medicaid benefits to include oral/dental, glasses, hearing aids, transportation and respite care	The Commission recommends that adult dental care be added to the Medicaid benefit package (Recommendation 24d). The Commission also recommends further study of Medicaid transportation benefits (Appendix X, #4). The Commission also recommends further study of respite care (Appendix X, #7).

[34] This rate is used by the CHP+ managed fee-for-service network.

Task Force Recommendation	How the Commission incorporated the recommendation
Allow Medicaid reciprocity with neighboring states	The Commission did not address this issue in its recommendations.
Realize cost savings by facilitating the transition of nursing home residents desiring community placement out of institutions	The Commission believes that it did not have enough time to adequately address long-term care in Colorado. Instead, the Commission recommends that Colorado conduct a comprehensive review of current Colorado long-term care information as a supplement to the Commission's recommendations (Recommendation 8)
Develop a process to evaluate in 2 years whether changes have had an impact on the health of Colorado's vulnerable populations and the number of uninsured.	The Commission recommends that Colorado direct the Value Authority to evaluate and report on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers. (Recommendation 16d)

Appendix 9: State Administrative Functions under Commission Recommendations

	Medicaid/CHP+	Subsidy Program	CoverColorado	Connector
Numbers of Coloradans Enrolled[35]	*886,300*	*215,400*	*24,100*	*Not estimated*
Marketing	✓	✓		✓
Eligibility and Enrollment	✓	✓	✓	
Broker Payments		✓	✓	✓
Benefit Design	✓	✓	✓	✓
Plan and Provider Contracting	✓	✓	✓	✓
Premium Billing		✓	✓	✓
Claims Payment	✓	✓		✓
Quality Assurance	✓	✓	✓	✓
Program Evaluation	✓	✓	✓	✓

[35] According to third round results from The Lewin Group. November 28, 2007

Appendix 10: Legal Issues

Appendix 11: List of Commissioners